Child and Family Counseling Group, Inc.

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AUTHORIZATION TO RELEASE INFORMATION

In regards to (*name of client*)____________________________date of birth_____________
I, (*name of parent, guardian, client*) _________________________hereby authorize
(*name of CFCG provider or therapist*)_____________________________, to:

- ☐ Request information from:
- ☐ Release information to:

(name of agency/person/organization)____
*(fax number/phone number)*____
*(street, city, state, zip).*____

Records may be copied and/or faxed. This disclosure is required for the following purpose: *(check all that apply)*

- ☐ Evaluation
- ☐ Treatment planning/course
- ☐ Other______________________________

I acknowledge that by authorizing the release of the information selected below, it discloses the fact that mental health services have been or are being provided. *(check all that apply)*

☐ Entire record	☐ Individual treatment plan	☐ Legal information
☐ Diagnosis	☐ Social history	☐ Discharge summary
☐ Dates of service	☐ Results of psychological and/or vocational testing	☐ Medical, neurological, or lab tests, such as EEG, EKG, etc.

This consent becomes effective (*date*)_______________________. This consent may be revoked in writing by the undersigned at any time, except to the extent that action has already been taken. If not revoked, this consent shall terminate at the end of:

- ☐ Six months
- ☐ One year
- ☐ Other (*specify date*)______________________.

I understand that I am to receive a copy of this authorization.

Signature of client Date

Signature of parent or guardian, if applicable Date