

Family First Counseling

17440 Dallas Pkwy., Ste. 216
Dallas, TX 75287

Authorization and Consent for Release of Information

Pursuant to Federal Guidelines concerning my right to confidentiality and state law concerning privileged communications, I hereby authorize Brandi Chiarello, LPC-S from Family First Counseling to communicate with:

Address/Phone: _____

In the following manner:

- to mutually disclose records/information, both written and verbal
- to request information
- to release information
- to exchange information via fax, email, phone, and face to face

Concerning:

The information to be used will be limited to the following (check any that apply):

- | | |
|---|--|
| <input type="checkbox"/> medical records (dates: _____) | <input type="checkbox"/> services, records, reports |
| <input type="checkbox"/> evaluation reports | <input type="checkbox"/> psychological testing results |
| <input type="checkbox"/> case notes | <input type="checkbox"/> mental health information |
| <input type="checkbox"/> other (specify): _____ | |

This authorization is in effect from _____ to _____.

I understand that if I am signing as the parent of a minor or as a guardian, the information released may contain references to me and my family. I understand that I may revoke this consent to release information at any time prior to the stated expiration above. I also understand that any release made between the time I authorized and then revoked shall not constitute a breach of my right to confidentiality.

Client Signature

Date

Parent/Guardian signature (if applicable)

Date