Emmaus Family Counseling Center

INDIVIDUAL • MARITAL • FAMILY THERAPY • CHILD • ADOLESCENTS

Authorization for Release of Information

I hereby authorize ____ to:

_____ Release To _____ Exchange With _____ Receive From

____
(Name of person, agency, or organization)

Address: ____

City: ______________________________ State: ___________ Zip code: ____________

Phone: ____________________________ Fax: _________________________________

The following information about: ____

_____ Treatment Summary
_____ Psychological Test Results/Reports
_____ Progress Notes
_____ School Records
_____ Medical Records
_____ Verbal Communication

This information will be used for the following purpose(s):

_____ Assessment _____ Treatment _____ Other: __________

This consent will automatically terminate in one year or on: ______________________________
It may be revoked at any time, in writing, by the undersigned.
I understand the potential advantages and disadvantages, if any, of releasing this information, and understand that treatment services are not contingent upon my decision to sign this release.

Client: ____ Date: ____________________

Parent/Representative: ______________________________ Date: ____________________

Witness: ____ Date: ____________________

Attention

Persons, agencies, or institutions to whom this information is disclosed are prohibited by Federal Law from disclosure without the written consent of the person to whom the information pertains. A general consent for the release of information is NOT sufficient for this purpose.