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RELEASE OF INFORMATION CONSENT FORM

PATIENT NAME_____ D.O.B. _____

I, hereby, authorize _____ to provide and/or receive information
(therapist name)

about myself/or my child's treatment to/from the following persons or agencies:

Name	Person/School/Agency	City	State	Zip	Phone
Name	Person/School/Agency	City	State	Zip	Phone
Name	Person/School/Agency	City	State	Zip	Phone

I understand that the information exchanged may include a record of myself or my child's participation in treatment, diagnostic findings, treatment recommendations, and/or a description of mine or my child's progress in treatment.

I understand that I may revoke this consent at any time by providing written notice. I have been informed about the nature of the information that will be given, its purpose, and who will receive the information.

Signature of Patient/Parent/Guardian _____ Date _____

Signature of Person Informing Client of Rights _____ Date_____