INNOVATIVE FAMILY THERAPY

AUTHORIZATION FOR RELEASE/EXCHANGE OF CONFIDENTIAL INFORMATION

Client Name: _____ DOB:_____

I, _____, hereby authorize to one of the independently contracted therapists of Innovative Family Therapy to RELEASE REQUEST SHARE (circle all that apply) confidential client information TO FROM WITH (circle all that apply)

_____ Phone:_____ Information shall consist of:

Duplicate records and/or verbal consultation concerning treatment and/or education. Specifically (circle all that apply):

TREATMENT SUMMARY DIAGNOSIS HISTORY/ INTAKE MEDICAL INFORMATION

MEDICATION HISTORY DATES OF TREATMENT/ATTENDANCE

SCHOOL INTERACTIONS/BEHAVIOR PLANS RECOMMENDATIONS OF THERAPIST

OTHER (PLEASE SPECIFY): _____

This authorization may be revoked at any time by the client. Revoking of this authorization shall not cancel any prior action that has already transpired. If not revoked, it shall terminate the last day of the clinical treatment.

The person signing this consent has a right to receive a copy of it. My initials, _____ indicate that I have received a copy of this authorization to release medical records.

I _____, have read and understand the nature of this release. I understand that I may revoke it at any time. I understand I have the right to refuse to sign this form, and that I may revoke my consent at any time (except to the extent that the information has already been released).

_____ _____

Signature of Client **Date**

_____ _____

Signature of Therapist **Date**

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