

Authorization to Release Confidential Records and Information & Consent to Communicate

This form provides Julia's Counseling & Play Therapy Group, PLLC to communicate with specified individuals or agencies regarding your child's treatment only in the case that the communication would benefit him/her. Information will only be shared verbally, fax, or a secured email address by both parties. The purpose of communication is for assessment and treatment planning. **Please fill out a new form for each person you request we communicate with.**

I, _____, hereby authorize Julia's Counseling & Play Therapy Group, PLLC to release and exchange information regarding _____ with the following individuals and/or organizations:

Person/Agency:

Relationship to client:

Address:

Apt. Unit #:

Phone number:

Fax number:

The information to be disclosed is as follows. Please check all that you are consenting to release and/or exchange.

Entire record

OR Specify by checking the following

Intake, diagnosis and treatment plan including psychotherapy notes

Discharge and summary of treatment

Educational testing and interventions

Medical reports

Other _____

I hereby authorize the release of my confidential protected health information, as described in my directions. I have had this form fully explained to me and fully understand this authorization to release records and information, including the nature of the records, their contents, and the consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may take back this consent at any time in writing, except to the extent an action based on this consent has already been taken. This release will be valid only until the termination of treatment or until withdrawn by patient's guardian in writing. **There is a fee associated with releasing a record, up to \$50. Payment must be made before release of records.**

Client / Guardian Full Name

Client / Guardian Signature

Date