FAMILY CHOICES COUNSELING CENTER	CLIENT NAME:
Therapist:	SS #:
CONSENT FOR RELEASE OF INFORMATION	Date of Birth:

I, _____, Client and/or _____,
Client's Name Legal Guardian if applicable by law

hear by authorize you to **(circle)** ***RELEASE*** or ***RECEIVE*** complete and legible copies of any and all written and verbal information concerning my or my legal ward's physical condition, care, treatment and court documents and other records relevant to my or my legal ward's care (circle) to or from: **(DO NOT SIGN IF LEFT BLANK.)**

Name of party to release/receive confidential information:

Address:

Telephone Number: Facsimile Number: : Email

Name of party to release/receive confidential information:

Address:

Telephone Number: Facsimile Number: : Email

for the purpose of_____

_____.
Statement of reason for release of confidential information

Information Requested:

A photocopy of this Authorization, which contains my signature, shall be considered as effective and valid and shall be honored by those to whom it is provided.

S I G N A T U R E S

CLIENT:	**DATE:**
LEGAL GUARDIAN:	**DATE:**
THERAPIST PRINTED NAME:	
THERAIST SINGATURE:	**DATE:**

REVOCATION

I, as authorizing agent, hereby exercise my right under the Freedom of Information Act to revoke this authorization, except for action already taken prior to this date.

S I G N A T U R E S

CLIENT:	**DATE:**
LEGAL GUARDIAN required if Client under age 14:	**DATE:**
THERAPIST PRINTED NAME:	
THERAPIST SINGATURE:	**DATE**