Family Resource Services at Crystal Lake, LLC

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Office: (860) 375-4060 Fax: (860) 812-2535 Website: www.familyresourceservicesllc.com

AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

This form cannot be used for the re-release of confidential information provided to Family Resource Services by other individuals or agencies. Such requests should be referred to the original individual or agency.

I _____ authorize _____ of
(Client) (Therapist's Name)
Family Resource Services at Crystal Lake, LLC to:

_____ release to:
_____ obtain from:
_____ exchange with:

_____

the following information pertaining to myself:

_____ treatment summary
_____ history/intake
_____ diagnosis & social/emotional treatment planning
_____ psychological test results
_____ psychiatric evaluation/medication history & management
_____ dates of treatment attendance
_____ other (specify)

for the purpose of:

_____ evaluation/assessment and/or coordinating treatment efforts
_____ other (specify) _____

This consent will automatically expire one (1) year after the date of my signature as it appears below, or on the following earlier date, condition, or event _____
_____.

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).

_____ Date of Birth: _____
Signature of Client Date

_____
Signature of Parent/Guardian Date