HopeSpring
Child & Family Clinic, LLC

♥ Authorization to Release, Request , & Consult Confidential Information ♥

I hereby authorize _____, **(Therapist's Name with Credentials).** to ***RELEASE:***

_____Assessment

_____Counseling or Psychological _____

_____Other:_____

Records for the client named below to the person or agency named below.

I hereby authorize _____, **(Therapist's Name with Credentials)** to ***REQUEST:***

_____Educational

_____Counseling or Psychological _____

_____Medical

_____Other:_____

Records for the client named below to the person or agency named below.

I hereby authorize _____, **(Therapist's Name with Credentials)** to ***CONSULT*** with the appropriate person or agency named below for the client named below.

Client Name: _____ DOB:_____

Agency/Office/School:_____

Name of Service Provider, Title:_____

Address:_____
City State Zip

Office Phone:_____ Office Fax:_____

I understand that I may revoke this consent at any time by informing the above parties in writing.

_____ _____
Client or Parent/Guardian's Name (Print) Date

_____ _____
Client or Parent/Guardian's Signature Date

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