CONSENT FOR RELEASE OF INFORMATION

Information being released by:

Family Concern Counseling, 2004 Valparaiso St, Valparaiso, Indiana 46383

Date____________________________

I (We) hereby authorize Family Concern Counseling to exchange the following information ____(Description of information to be released)

With the following person(s) or organization.

(1) Ccounselor____

(2) Physician____

(3) Psychologist____

(4) School____

(5) Other (specify)____

Name or title of the person or organization, including contact information, to which the exchange is to be made: (Exchange will not be made without complete information)

Name____

Address____

City__________________________________ State_________ Zip_______________

Phone_________________________________Fax______________________________

NAME OF CLIENT____ Age_________

The purpose of this exchange or disclosure of information is: (Exchange will not be made without complete information) ____

I understand that I may revoke this release at any time, except to the extent that the practice has taken action in reliance of the consent. Such revocation must be in writing and submitted to the office manager in person, by US mail or e-mail. The consent is valid until revoked; otherwise it will expire on the following date or event_____________(unless otherwise noted 60 days from issue date.) Please be advised this authorization does not protect the information from being disclosed by the recipient.

Date of information issue_________________________

____ __________________

Signature of Client Date

____ __________________

Signature of Parent/Guardian Date