Release of Information for the Counseling of a Minor

2004 Valparaiso Street, Valparaiso, Indiana 46383 ▪ 219-477-5646 ▪ FAX 219-476-3190 ▪ info@familycounsel.org ▪ www.familycounsel.org

Date _____

Name of minor _____

Name or title of the person (Managing Conservatorship) or organization that is releasing this minor for counseling:

Name _____

Address _____

City _____ State _____ Zip _____

Phone – Work _____ Cell _____

I understand that I may revoke this release for counseling at any time, and that I must do so in writing.

Party responsible for payment of fees:

Name _____

Address _____

City _____ State _____ Zip _____

Phone – Work _____ Cell _____

Information being released by:
Family Concern Counseling, 2004 Valparaiso Street, Valparaiso, Indiana 46383
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) Counselor Name _____

_____(2) Physician Address _____

_____(3) Psychologist City _____ State _____ Zip _____

_____(4) School Phone – Work _____ FAX _____

_____(5) Guardian 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.

Signature of Managing Conservator _____ Date _____

Signature of Conservator _____ Date _____