



Release of Confidential Information

I, _____ (client, parent, or legal guardian of child) hereby authorize a two-way disclosure of information between Cindy Hatcher and

I understand that the above name is no longer responsible for the safeguarding of this information and is held harmless as to its uses after release. I understand that such disclosure will be made to provide for proper case management and counseling services. I am aware that this information will not be shared beyond those who have a need to know in the offices of those mentioned in this release.

I understand that services rendered are not contingent upon signing this release. I understand that I may revoke this consent at any time, except to the extent that information has already been obtained. Otherwise, the expiration date of this release shall be ONE YEAR from the date signed below. The following information is to be released:

- | | |
|---|--|
| <input type="checkbox"/> Testing results/interpretation | <input type="checkbox"/> Attendance in therapy |
| <input type="checkbox"/> Diagnostic impressions | <input type="checkbox"/> Course of treatment |
| <input type="checkbox"/> Summary of treatment | <input type="checkbox"/> Outcome of treatment |
| <input type="checkbox"/> Other (specify) | |

Name of person(s) information pertains to: _____

This information is **NOT** to be transferred to any other person or agency without specific written permission from the person(s) whose signature(s) appears below.

A photocopy of this authorization shall be considered as effective and valid as the original.

AUTHORIZING SIGNATURES:

Name of Client/Parent, Please print Client/Parent/Guardian signature Date Signed

