

## Consent for Release or Exchange of Confidential Information

Name of Client: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

I hereby authorize the **release and exchange of information** between my therapist, \_\_\_\_\_, (therapist's address) \_\_\_\_\_ and the following individual, agency, or institution:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

E-Mail: \_\_\_\_\_

This authority extends to the furnishing of copies of all or any desired portion of the records pertaining to the above-named client. This exchange is for the purpose of \_\_\_\_\_ and expires five years from the date signed unless otherwise specified. The client has a right to retain a copy of this release.

The parties named above are hereby released from all legal liability that may arise from this exchange or release of information. I understand that I may revoke this consent at any time by informing all of the above parties in writing. A photocopy or electronic copy is as valid as the original. This is a strictly confidential patient medical record. Re-disclosure or transfer is expressly prohibited by law.

Signature: \_\_\_\_\_ Date \_\_\_\_\_  
Client

Signature: \_\_\_\_\_ Date \_\_\_\_\_  
Parent or Guardian