

Family Options Counseling, LLC

Aggression Replacement Training

Release of Information

Client name: _____

D.O.B: _____

1. I authorize the following information to be disclosed.
 - Treatment progress
 - Treatment summary
 - Provision of treatment services
 - Diagnosis
 - Previous treatment progress

2. I authorize the following persons/organizations to *exchange* the above information and records.
 - Dr. Kimberly Young
 - Family Options Counseling, LLC
 - Wraparound Milwaukee
 - Milwaukee Children’s Court
 - District Attorney’s Office
 - Juvenile Probation
 - Other treatment providers (list therapist’s below)

therapist

phone

therapist or other

phone

3. I understand that the information being exchanged covers an unlimited time period (birth to present).

4. I understand that this authorization may be revoked at any time upon my written request. This authorization will expire in one year, unless an earlier date is specified as follows: _____

5. I understand that there are limits to confidentiality that do not require my release of information. The following types of information will be reported without my consent.

- Suspected child abuse or neglect (past or present)
- Threats of self harm
- Threats of harm toward specific others

Client's signature

Date

Legal Guardian (if client is under 18)

Date