Family Options Counseling, LLC
Release of Information

Client ID#: _____

Client Name: _____

Client's Guardian: _____

Client's DOB: _____

I understand that my treatment information is confidential. I authorize Family Options Counseling to do the following with my treatment information:

☐ Release my treatment information to the following individuals or agencies:

_____

_____

_____

☐ Exchange my treatment information with the following individuals or agencies:

_____

_____

_____

I understand that this authorization will expire in one year unless a different date is indicated.
Adjusted date: _____

I understand that the treatment information being disclosed includes any information from birth to the end of my treatment unless otherwise specified below.
Time period: _____

I understand that I an authorizing any of my treatment information to be disclosed unless otherwise specified below:
Specific information disclosed: _____

_____

_____

_____ _____
Client's Signature (if 14 years old) Date

_____ _____
Guardian's signature (if client is under 18) Date

_____ _____
Therapist's signature Date