**Family Options Counseling, LLC**

***CHOICES***

**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.

* 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

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Client’s signature Date

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Legal Guardian (if client is under 18) Date