Family Options Counseling, LLC
Social Skills Program for Kids

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. Please cross out and initial any agencies that do not apply.
   - Family Options Counseling, LLC
   - Children's Court *County* -_____
   - District Attorney's Office *County* -_____
   - Juvenile Probation *County* -_____
   - Wisconsin Department of Corrections
   - Social Services *County* -_____
   - 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