Authorization for Internal Release of Information

The Child & Family Counseling Group, P.L.C. is an outpatient mental health facility, which has an interdisciplinary staff. Occasionally, staff members need to consult with each other in order to provide the best possible care for their clients. This may necessitate the sharing of client information. When this pertains to you, we require your written permission.

By signing this form, you will be authorizing us to internally exchange both verbally and in written form any information we have obtained from you and which we have available to use within The Child & Family Counseling Group, P.L.C.

We assure you that all information used and shared will be so judiciously and in the service of providing you better treatment.

_____ _____

Date **Patient Signature**

_____

Parent Guardian Signature (if under 18)

_____

Print Patient Name