Hope for Healthy Families
COUNSELING CENTER

CONSENT TO RELEASE

CONFIDENTIAL INFORMATION

By signing this document, I, _____, hereby authorize the exchange of information between Hope for Healthy Families Counseling Center staff and _____ at _____, for the purpose of _____.

I authorize information and records obtained in the course of my diagnosis and/or treatment to be disclosed. Such disclosure shall be limited to the following specific types of information:

_____

_____

_____

I understand that I have a right to receive a copy of this authorization. I also understand that any cancellation or modification of this authorization must be in writing. This authorization shall remain valid until _____ or one year from the date of authorization.

Signature_____ Date _____

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