

INSTITUTE FOR COUPLE AND FAMILY ENHANCEMENT

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San Antonio, TX 78232

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CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

OUTSIDE ORGANIZATION OR INDIVIDUAL

Name and Contact Information _____

CLIENT INFORMATION

Client Name: _____ Date of Birth: _____

Parent's Name (if minor client): _____

Complete Address: _____

Information to be released:

- Confirmation of attendance in therapy sessions
- Evaluation/Assessments
- Diagnosis
- Therapist progress notes
- Treatment Plan
- Recommendations for educational setting
- Complete medical record (not including therapist progress notes)
- Recommendations for outside party to support therapeutic goals

Purpose of disclosure of private health information: _____

This release is subject to revocation by the undersigned at any time except to the extent that action has already been taken in reliance thereon. Revocation must be submitted in writing. Consent to release private health information is voluntary; refusal to provide consent with an outside party may not be a condition of treatment unless treatment is mandatory by court order or other Local, State, or Federal authority. Neither the ICFE nor its therapists are responsible for confidential information which is passed by the outside individual/ organization named above to any party not named in this release. This release expires six months after termination of therapy services by the therapist names below.

Type of Release Granted:

- ONLY FROM** the ICFE therapist named below TO the Outside Organization/Individual
- ONLY TO** the ICFE therapist named below FROM the Outside Organization/Individual
- BETWEEN** the ICFE therapist named below AND the Outside Organization/Individual

ICFE Therapist: _____

ICFE Therapist Direct Phone: _____

Client Signature:

Parent or Legal Guardian Signature (if client is minor):

DATE

DATE