Sacred Space Counseling Center DFW
800 Airport Freeway, Suite 745
Irving, Texas 75062

AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION FOR MINOR

This form cannot be used for the re-release of confidential information provided to the Counseling Center by other individuals or agencies. Such requests should be referred to the original individual or agency.

Child's name: _____ DOB: _____

I, _____, authorize the Counseling Center to:

_____ release to: _____ obtain from: _____ exchange with:

Name: _____

Address: _____

Phone Number: _____

Fax Number: _____

_____ verbally _____ in writing

the following information pertaining to my child's:

_____ treatment summary
_____ goals of treatment
_____ diagnosis
_____ history/intake
_____ dates of treatment attendance
_____ other: _____

for the purpose of:

_____ evaluation/assessment and/or coordinating treatment efforts
_____ other (specify) _____

This consent will automatically expire one (1) year after the date of my signature as it appears below.

I understand I have the right to refuse to sign this form, and that I may revoke my consent at any time (except to the extent that the information has already been released).

_____ _____
Signature of Parent/Legal Guardian Date

Social Security# or Date of Birth: _____

_____ _____
Signature of Witness Date