

Katz Counseling and Educational Psychology, Inc.

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CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

I, _____
(Print Client, Parent, Guardian or Legal Representative's Name)

hereby authorize and request that Katz Counseling and Educational Psychology

Release to Receive from Bi-Directional Release (sharing)

_____ Relevant mental health, medical, educational, or legal information

_____ Billing & Scheduling Information

Name: _____

Phone: _____ Fax: _____

List any information that you do **not** wish to disclose _____

Regarding: _____ My child (child's name): _____
_____ Myself

This information will be used to facilitate treatment and/or evaluation of myself or my child.

This authorization shall remain in effect until (check one):

_____ Treatment/assessment has been completed
_____ Date: _____
_____ Event: _____
(fill in an event that relates to the individual or the purpose of the use or disclosure)

I understand that I may revoke this authorization, in writing, at any time by sending such written notification. I also understand that information used or disclosed pursuant to this authorization may be subject to be disclosure by the recipient and is no longer protected by HIPAA Privacy Rules. I further understand that information received from third parties may be protected information and unable to be disclosed by this office upon receipt.

Signature of Client

Date

Signature of Parent, Guardian or Legal Representative

Date