Freedom First Psychological Services, PLLC
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CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

In regard to my child, _____ I,

_____ (parent/guardian) authorize staff at Freedom First Psychological Services, PLLC to disclose information/records to and receive information/records from:

Name of Outside Agency: _____

Name of Provider from Agency: _____

Agency Address: _____

_____

Provider's Phone Number: _____

Provider's Fax Number: _____

Type of Records: _____

I understand that my child's records are protected under Federal Confidentiality Regulations (45CFR Parts 160 and 164) and cannot be disclosed to outside individuals without my written consent unless otherwise provided for in the regulations. I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. I also understand that this consent expires automatically 1 year from this date. In situations necessitating emergency medical/psychiatric treatment, information necessary to facilitate emergency care in said situation will be provide to treatment personnel without a signed release.

Parent/Guardian Signature: _____

Date: _____