Solutions Family Therapy

Authorization for Release of Confidential Information

I authorize *Solutions Family Therapy* to disclose my health information to the persons listed below. This includes any records, reports, test results, opinions, assessments and any other information relating to medical, emotional, educational or psychological condition.
I can revoke this agreement at any time by sending a written notice to the *Solutions Family Therapy* office where I am receiving services.
I understand that information disclosed under this authorization may be subject to redisclosure by the recipient and may no longer be protected by *Solutions Family Therapy* confidentiality rules.
I waive any right of privacy that I may have in connection with the disclosures hereby authorized.
This authorization is valid until three months after my file is closed at *Solutions Family Therapy.*

Insurance company: Client's initials:

Name: Client's initials:

Name: Client's initials:

Name: Client's initials:

Name:

Client's signature: Date:

Client's signature: Date:

Witness: Date: