Cornerstone

Family Therapy LLC

CORNERSTONE FAMILY THERAPY ~ 1415 LINCOLNWAY WEST SUITE T OSCEOLA, IN 46561~
PHONE: (574)651-8912 FAX (574) 281-4412

Request/Authorization to Release Confidential Records and Information

Client Name:	Date of Birth:

I give permission for Cornerstone Family Therapy to release/receive information from:

Person or Agency:

Address:

Phone Number:

Fax/Email:

	The following information regarding the client/family?		For the purpose of:
	Initial Assessment		Coordination of Services
	Information on Progress in Therapy		To Assist in Evaluation
	Treatment Plan		To Provide Continuity of Treatment
	Termination Summary		Other:
	Other:		

I understand that I can revoke this authorization at any time, except to the extent that action has already taken place. If not revoked at an earlier date, this authorization will expire one year from the date signed.

Form of Disclosure

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

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Signature of Patient/Client Date

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Signature of Parent, Guardian or Personal Representative Date