

Authorization for Release/Exchange of Information of a Minor

Client name

Date of birth

Custodial Parent/Legal Guardian name

Relationship

authorizes (check therapist given authorization):

- | | |
|---|--|
| <input type="radio"/> Kristen Santel, LISW-S | <input type="radio"/> Emily Hunter, MSW, LSW |
| <input type="radio"/> Cassie Campbell, LISW | <input type="radio"/> Deborah Cannon, LISW |
| <input type="radio"/> Maeve Rising, LISW | <input type="radio"/> Molly Boggs, LPCC |
| <input type="radio"/> Danielle Weatherholtz, LPCC-S | <input type="radio"/> Kelly Chambers, LPCC |
| <input type="radio"/> Jande Thomas, LPC | <input type="radio"/> Amanda Keller, LPCC |
| <input type="radio"/> Nicki Cristina, LPCC | <input type="radio"/> Kimberly Morales, LISW-S |
| <input type="radio"/> Jonathan Sherman, LISW | <input type="radio"/> Kathleen Gibbs, LPCC |
| <input type="radio"/> Katherine Pontious, MSW, LISW | <input type="radio"/> Autumn Eckstein, MSW, LISW |
| <input type="radio"/> Claire Miller, MSW, LSW | <input type="radio"/> Emilee King, LPC |
| <input type="radio"/> Haley Gniadek, MSW, LSW | <input type="radio"/> Justin Richards, LPC |
| <input type="radio"/> Brandi Allen, LPC | <input type="radio"/> Dyaniese Brown, MSW, LSW |
| | <input type="radio"/> SWT/CT: _____ |

to release/exchange my medical information to/with:

(specific person/organization authorized to receive/exchange information)

The information to be released is:

- | | |
|---|--|
| <input type="radio"/> Verbal Narrative Summary of Treatment | <input type="radio"/> Diagnostic Assessment |
| <input type="radio"/> Treatment Plan | <input type="radio"/> Written Summary of Treatment |
| <input type="radio"/> Bio/Psychosocial History | <input type="radio"/> Family History/Family Dynamics |
| <input type="radio"/> Session Notes** | <input type="radio"/> Other _____ |

**Session Notes do not include psychotherapy notes which may be kept for the use of the therapist in ongoing treatment. A separate release is required for psychotherapy notes. Exceptions to information to be released: _____

This Authorization will expire upon termination of treatment. I understand I have the right to shorten the authorization period if noted here: _____ (date of expiration). I understand I have the right to revoke this authorization in writing at any time and that the revocation will be effective except to the extent that my therapist has already taken action in reliance on this authorization. I also understand that once the information is released it may no longer be covered by law and may be re-disclosed by the recipient.

Signature of Custodial Parent/Legal Guardian

date signed

printed name

Note: This information has been disclosed to you from records whose confidentiality is protected from disclosure by State and Federal Law, ORC 5122.31, 45 CFR Part 2, and/or OR 3701.243, prohibiting you from making any further disclosure of it without the specific informed release of the individual to whom it pertains, their authorized representative, or as otherwise permitted by law. A general authorization for release of information is not sufficient for this purpose.

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