

Consent to Release Information - Family

I, _____ hereby authorize Cameron Wardlaw
Client Name – Printed
and the party delineated below to disclose and/or obtain information and/or records regarding my diagnosis and treatment and other pertinent information. I realize that the exchange of information between all parties is for the purpose of assisting all involved in properly treating me and facilitating transition of care.

Father: Name _____
Address _____
Phone _____ Fax _____

Mother: Name _____
Address _____
Phone _____ Fax _____

Spouse: Name _____
Address _____
Phone _____ Fax _____

Other: Relationship _____
Name _____
Address _____
Phone _____ Fax _____

I understand that my records are protected under the federal regulations governing Confidentiality of Patient Records, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

Consent Expires on (Date: _____). If no date is specified then the release is valid for one year from the date below. If a client wishes to revoke their consent they should speak to their Therapist and complete the Revocation of Consent to Release Information Form.

Client or Guardian Signature Date

Therapist's Signature Date