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Individual & Family Therapy
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Consent For The Release Of Confidential Information

I, _____ of _____
(name) (address)

authorize Karren Garrity, Therapist to disclose and discuss any and all information pertinent to the counseling process with the following_____.
(agency/school/individual)
I understand that my records are protected under the Federal and State Confidentiality Regulation 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 anytime except to the extent that action has been taken in reliance (e.g. probation, parole, etc.) and that in any event this consent expires on the following date: _____.
I further acknowledge that the information to be released was fully explained to me and this consent is given of my own free will.

Executed this _____ day of _____ 2_____

_____
Signature of participant

_____
Signature of Parent/Guardian

Please share the contact information for above noted agency, school, doctor or therapist.

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