AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I, _____, hereby authorize the following people to disclose information about my / my child's *(circle one)* medical records to The River Wellness Group staff, for the purpose of facilitating treatment *(please include name and phone number)*:

_____

_____

_____

_____

and for The River Wellness Group to disclose:

☐. all information relevant to my/my child's (circle one) case.

☐. only that I/my child (circle one) am/is in treatment.

☐. only the following information:

_____

_____

_____

_____

This authorization shall be voided at the termination of therapy or at any such time as I choose to revoke it in writing.

Name of Client/Parent (print) _____

Signature _____ Date _____