INSTITUTE FOR COUPLE AND FAMILY ENHANCEMENT
21015 Market Ridge Ste. 101
San Antonio, TX 78258
Tel. (210) 496-0100 Fax. (210) 496-0101 Website: www.icfetx.com

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

OUTSIDE ORGANIZATION OR INDIVIDUAL

Name and Contact Information _____

_____

CLIENT INFORMATION

Client Name: _____ Date of Birth: _____

Parent's Name (if minor client): _____

Complete Address: _____

Information to be released:

- ▫ Confirmation of attendance in therapy sessions
- ▫ Evaluation/Assessments
- ▫ Diagnosis
- ▫ Therapist progress notes
- ▫ Treatment Plan
- ▫ Recommendations for educational setting
- ▫ Complete medical record (not including therapist progress notes)
- ▫ Recommendations for outside party to support therapeutic goals

Purpose of disclosure of private health information: _____

This release is subject to revocation by the undersigned at any time except to the extent that action has already been taken in reliance thereon. Revocation must be submitted in writing. Consent to release private health information is voluntary; refusal to provide consent with an outside party may not be a condition of treatment unless treatment is mandatory by court order or other Local, State, or Federal authority. Neither the ICFE nor its therapists are responsible for confidential information which is passed by the outside individual/ organization named above to any party not named in this release. This release expires six months after termination of therapy services by the therapist names below.

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Type of Release Granted:

☐ **ONLY** *FROM* the ICFE therapist named below *TO* the Outside Organization/Individual
☐ **ONLY** *TO* the ICFE therapist named below *FROM* the Outside Organization/Individual
☐ *BETWEEN* the ICFE therapist named below *AND* the Outside Organization/Individual

ICFE Therapist: _____

ICFE Therapist Direct Phone: _____

Client Signature: _____ DATE

Parent or Legal Guardian Signature (if client is minor): _____ DATE