Integrative Counseling Services, PLLC
Counseling-Consulting-Play Therapy
Jodi Mullen, PhD LMHC NCC RPT-S Director
www.integrativecounseling.us

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6221 Route 31 Suite 110 Cicero, NY 13039 315.699.5123
6734 Pine Ridge Road Auburn, NY 13021 315.253.4630
104 Cayuga Street Fulton, NY 13069 315.402.2946

Authorization for Release of Confidential Information

I, _____, parent/guardian of_____,
DOB _____ hereby authorize Integrative Counseling Services and/or a Representative of the Play Therapy Clinic to seek/release information to/from:

Name: _____
Address: _____
_____Phone:_____

Extent of nature of this information:
(Check all that apply)

YES	NO	
()	()	Attendance
()	()	Recommendations
()	()	Discharge Summary
()	()	Progress in Treatment
()	()	Treatment Plan
()	()	_____

The purpose or need for such disclosure(s) is/are:

()	Confirmation of Attendance	()	Coordination of Treatment
()	Legal Concerns	()	Confirmation of Progress
()	Referral	()	_____

I understand that the confidentiality of my records will be respected to applicable laws and regulations. I also understand that I may revoke this consent at any time, except to the extent that action has already been taken. This consent, unless revoked earlier in writing expires on:

()	90 days following dated signature	()	90 days following treatment
()	Upon completion of treatment	()	_____

I further acknowledge that the information to be released was fully explained to me and this consent is given of my own free will.

_____ _____
Signature of Legal Guardian Date