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Consent for Release of Information Adolescent Client

I authorize written release/disclosure and verbal exchange and of information regarding my care between Stacey Blank, MA, LPC, CACIII and the below noted party. The information disclosed will be reviewed with client prior to exchange of information and any concerns discussed. The only exceptions to this involve emergency situations (medical crisis, suicidal or homicidal ideation/intent or risk of imminent harm to the client) where action is required for protection of the client.

Name _____

Phone _____

I have read, understood and received a copy of the information presented in this document.

Client

Date

Parent or Guardian

Date

Witness

Date

I withdraw my consent for the above noted person to have contact with Stacey Blank, MA, LPC, CACIII

Client

Date

Parent or Guardian

Date