



Family Life Education

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby give my permission for _____

Relationship to Client:

____ Attorney ____ Children's Attorney ____ Counselor/Therapist
____ School Personnel ____ Other: _____

TO RELEASE AND DISCUSS ANY CHILD CARE, INVESTIGATIVE, MEDICAL, PSYCHOLOGICAL, PSYCHIATRIC, SOCIAL, CHILD SUPPORT, VOCATIONAL, AND/OR EDUCATIONAL INFORMATION CONCERNING MYSELF OR MY CHILDREN. I UNDERSTAND THIS REQUEST FOR INFORMATION INCLUDES MY CONSENT FOR RELEASE OF INFORMATION. I UNDERSTAND THIS REQUEST FOR INFORMATION INCLUDES MY CONSENT FOR RELEASE OF INFORMATION ON ILLEGAL DRUG USE, DISEASES, AND ANY TESTING ON MYSELF OR MY CHILDREN.

I UNDERSTAND INFORMATION USED OR DISCLOSED PURSUANT TO THIS AUTHORIZATION MAY BE SUBJECT TO REDISCLOSURE AND NO LONGER PROTECTED. I UNDERSTAND TREATMENT OR PAYMENT CANNOT BE CONDITIONED ON SIGNING THIS AUTHORIZATION.

I understand that my records are protected under federal and state regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations or by court order. I also understand that I may revoke this authorization by writing the word "Revoke," my signature, and the date across this form at any time after signed, except to the extent that action has been taken in reliance on it. I also understand that permission to release family records must come from all family members of the family age 18 or over participating in the services, or information released must be restricted only to information regarding the person/s who signs the release. This release is effective for one year from signed date unless otherwise revoked.

This information may be released to: _____ of Parenting Partnerships, Inc.

For the purpose of:

____ Co-parenting Assistance ____ Parenting Coordination
____ Family Coaching ____ Other: _____

_____ Name (print)	_____ Signature	_____ Date
_____ Name (print)	_____ Signature	_____ Date
_____ Family Life Educator (print)	_____ Signature	_____ Date