A Place to Grow and Heal

Consent for Release/to Obtain Confidential Information For Minors

I, _____, parent of _____

date of birth: _____ hereby give **A Place to Heal and Grow** permission to release/to obtain confidential information to the following individual(s) and/or organizations:

Name:_____ Relationships:_____

Address: _____

City/State/Zip:_____

Phone: _____

This information may include verbal, written and electronic communication for the purposes of

_____

I understand that these records are confidential and may be covered under the federal regulation governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR Part 2) and cannot be disclosed without written consent. I understand that I may revoke this consent at any time. I understand that this cannot apply to information already released.

Unless revoked sooner, this consent will expire on _____, one year form the date of authorization, or 60 days past the termination of counseling services.

Parent/Guardian:_____ Date:_____

Signature of Witness:_____ Date:_____