Solomon Family Services
Charmaine Solmon, M.A. LPC, RPT
1524 Independence Pkwy, Suite J
Plano, TX. 75075
Ph. 469-361-1372 Fax 469-361-6350
www.csolomonlpc.com

Consent to Release Information

Client name_____ Date_____

I, _____, consent to release information regarding my own or my child's therapy and /or testing with _____

Or to the following individual (s): _____

_____

_____

Information to be released or exchanged includes (check all that apply):

_____Discharge and summary _____ Progress Notes

_____Behavioral Health Treatment Records _____Medication Records

_____Case Summary _____School records

Other (Specify) _____

This authorization shall expire: _____

I understand that I may withdraw my consent at any time. I understand that my health and behavioral health records are protected from being shared under Federal and state laws. I may change this permission. This permission is valid until changed or sixty (60) days after I have completed treatment, whichever is sooner. Once I revoke this permission, no information can be released except as allowed by law. A file copy is as good as the original.

This authorization was explained to me and I signed it of my own free will:

Signature of Client/Parent_____ Date: _____

Signature of Witness_____ Date: _____