Family Restoration
COUNSELING SERVICES

Consent to Release Information

In some instances, sharing information is necessary to provide the best possible treatment and care. Examples of those who could benefit from sharing information include present or past therapists, physicians or psychiatrists that may have treated you in the past, school counselors, teachers who are involved in your care, or parents. Your information will only be shared if your express permission is given in writing.

By signing below, consent will be given to release otherwise confidential information. Family Restoration Counseling Services (FRCS) will receive or give information to the entity named below. Information may be shared for the purpose of treatment planning, assessment information, coordination of services, psychosocial information, discharge planning, or other forms of clinical services. Information will be shared between:

Family Restoration Counseling Services
Primary Office:
8340 Meadow Rd.
Dallas, TX 75231
(214) 270-1777
AND

_____
Name of Person or Organization

_____
Street, City, State (Zip)

_____ _____
Phone Fax

I understand that this consent to release information will only be released to the following person(s), and will expire exactly one year from the date of signing, or through my written consent as client.

_____ _____ _____
Client Name (Printed) Signature Date

_____ _____ _____
Guardian Name (Printed) Guardian Signature (if client under 17) Date