FFCS

Families First Counseling Services
Jeffrey N. Rose Ed.S., LMFT

RELEASE OF INFORMATION

I hereby authorize **Jeffrey N. Rose dba Families First Counseling Services** to send clinical/counseling information to:_____ or request clinical/counseling information about me from:_____ for the purposes of_____.

I understand the need for the exchange of information and that there are statutes and regulations protecting the confidentiality of authorized information. I understand that this consent is truly voluntary and is valid until _____ (date not to exceed one year). I also understand that I may withdraw this consent at any time except to the extent that the information has already been received or obtained.

Client Name: _____

Address: _____

_____

Phone: _____

Signed: _____
Signature of Client Date

_____
Printed or typed name

_____
Signature of parent if child is minor

_____
Printed or typed name of parent

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