BLISSFUL MARRIAGE & FAMILY THERAPY

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CONSENT TO RELEASE CONFIDENTIAL INFORMATION

CASE #: _____

CLIENT: _____ DATE OF BIRTH: _____

I authorize and give my consent for Adrianne Bliss-Williams, to request and/or release information, as described below, contained in my confidential record, regarding (myself, my child), to the following individual or organization:

_____

INFORMATION TO BE RELEASED: _____

_____

This information is being released for the purpose of, and subject to the following limitations: _____

By signing this consent I agree to hold harmless Dr. Adrianne Bliss-Williams, if this released information is handled inappropriately, or in any manner detrimental to me, or fails to result in the desired outcome with any third party or other agencies with whom I may have applied for benefits of any kind.

This release is valid through _____. However, I understand that I may revoke this release at any time by so stating in writing. A photocopy of this release is as valid as the original.

_____ _____ _____
Signature of Parent or Guardian Date Printed Name

_____
Relationship to client (if client is a minor)

_____ _____ Dr. Adrianne Bliss-Williams
Witness Signature Date