Ancient City Children's Therapy, LLC
910 S. Winterhawk Dr. # 107
St. Augustine, Fl. 32086
(904) 826-7886

Consent for Release of Client Information

Client Name:
DOB:
Client SS Number:

I, the above named hereby authorize _____

(Name of Agency or person to release information)

to release specified information to _____

(Name of Agency or Person to receive information)

and in addition authorize _____ to release

(Name of Agency or person to release information)

specified information to_____

(Name of Agency or person to receive information)

This information shall include only that of the nature and to the extent to which is specified below:_____

_____

This information will be used for_____

I understand the contents to be released, the need for the information, and that there are state and federal regulations protecting the confidentiality of authorized information, and that it cannot be released without my written consent unless otherwise provided for in the regulations. I hereby acknowledge that this consent is truly voluntary and is valid for a period not to exceed one year. I further acknowledge that I may revoke this consent at any time except to the extent that action based on this consent has been taken. A revocation of consent must be in writing.

_____

Client Signature or Parent/Guardian Legal

_____ _____

Witness **Date of Consent**