



INSIGHTS COLLABORATIVE THERAPY GROUP

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CONSENT TO RELEASE

(minor)

I authorize _____ to release to, obtain from, and discuss with name:
_____ phone: _____ the following
information concerning my minor child _____ (client to check each item to be disclosed):

- | | |
|--|--|
| <input type="checkbox"/> Assessment | <input type="checkbox"/> Testing Information |
| <input type="checkbox"/> Diagnosis | <input type="checkbox"/> Educational Information |
| <input type="checkbox"/> Psychosocial Evaluation | <input type="checkbox"/> Presence/Participation in Treatment |
| <input type="checkbox"/> Psychological Evaluation | <input type="checkbox"/> Continuing Care Plan |
| <input type="checkbox"/> Treatment Plan or Summary | <input type="checkbox"/> Treatment Progress |
| <input type="checkbox"/> Current Treatment Update | <input type="checkbox"/> Billing Records Only |

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and, when appropriate, coordinate treatment services.

On behalf of my child, I waive my child's right to confidentiality of the information and records released, obtained and discussed under this Consent. I release Insights Collaborative Therapy Group and its staff from all liability arising from release, disclosure and discussion of my child's confidential information and records.

This Consent expires _____. I acknowledge I have the right to revoke this Consent in writing at any time to the extent action in reliance on this Consent has not been taken. I acknowledge that even if I revoke this Consent, the use and disclosure of my child's protected health information could possibly still be compelled as required by law. I have been advised of the potential of the redisclosure of my child's protected health information by the authorized recipients.

I acknowledge that the treatment provided to my child by Insights Collaborative Therapy Group was not conditioned on my signing this authorization. I acknowledge I signed the original of this Consent to Release and received a copy of it.

DATED: _____, 201__.

Client:

Client Signature

Client Name Printed