CONSENT TO RELEASE
(minor)

INSIGHTS COLLABORATIVE THERAPY GROUP
8140 Walnut Hill Lane, Suite 450
Dallas, Texas 75231
214.706.0508
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Select clinician:

- ☐ Dr. Jeff Baldridge, PhD (jbaldridge@insightstherapy.com)
- ☐ Mary Sanger, LMFT-S, LPC-S, LCDC (msanger@insightstherapy.com)
- ☐ Murphy Foster, LPC (mfoster@insightstherapy.com)
- ☐ Laura Pierce, LMFT-S, RPT, IMH-E (laura@insightstherapy.com)
- ☐ Shawn Chrisman, PhD, LPC (schrisman@insightstherapy.com)
- ☐ Jennifer Aguilar, LPC (jennifer@insightstherapy.com)
- ☐ Elizabeth McConnell (elizabeth@insightstherapy.com)
- ☐ Other: ____

I authorize the above selected clinician to release to, obtain from, and discuss with _________________

____ the following information concerning

my minor child, ____:

- ☐ Assessment
- ☐ Diagnosis
- ☐ Psychosocial Evaluation
- ☐ Psychological Evaluation
- ☐ Treatment Plan or Summary
- ☐ Current Treatment Update
- ☐ Testing Information
- ☐ Educational Information
- ☐ Presence/Participation in Treatment
- ☐ Continuing Care Plan
- ☐ Treatment Progress
- ☐ Billing Records Only
- ☐ Alcohol and Substance Abuse

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: ______________________________

____
SIGNATURE

____
PRINTED NAME