Seasons Promise
Permission for Collaboration / Release of Information

In counseling, it is often helpful to discuss relevant information with others, which is normally confidential. Please check any below you feel are relevant for best counseling outcomes, including names and contact information. Information shared will be that information relevant to your or your child's care only.

_____ 1. Physician or Medical Provider: ____

_____ 2. Teacher or Work Contact: ____

_____ 3. Other mental health providers: ____

_____ 4. Child's other parent or Your Partner: ___________________________________

_____ 5. Other: ____

_____ 6. Other: ____

In each of these situations only information that is needed will be disclosed to provide as much privacy as possible. Please circle why collaboration is helpful for you: treatment planning, medication management, implementing treatment, other: __________________ .

This release expire on __________________, can be modified at any time by crossing off the name listed above, and will cease when counseling ends. Disclosures required under law in the confidentiality notice cannot be amended, such as suspicion of child or elder abuse.

Disclosures to third parties may not be protected if they are not a covered HIPPA entity.

Name Date