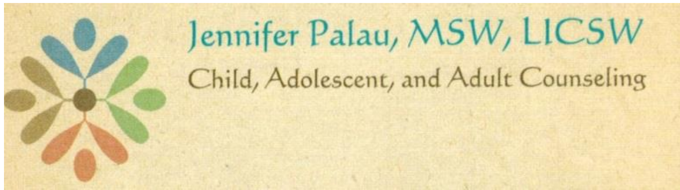

17090 Avondale Way NE
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425.223.0085
jenniferpalau@yahoo.com
www.jenniferpalau.com

Consent to Release/Receive Confidential Information

I, ____

(Client, Parent or Guardian)

Hereby authorize ____________________________________

(Name of Therapist)

To release and receive information to/from the following person(s):

____

(Name of Person, Institution, Government or Medical Agency)

____

(Address and Telephone Number)

____

(Name of Person, Institution, Government or Medical Agency)

____

(Address and Telephone Number)

____

(Name of Person, Institution, Government or Medical Agency)

____

(Address and Telephone Number)

The following specific information:

____

____

____

I am aware of and expect that all information is confidential and is protected by the policies of Jennifer M. Palau, MSW, LISCW, the agency requesting and receiving the above information, and by State and Federal regulations.

______________________________ ______________________________

Client/Parent or Guardian Signature/Date Client/Parent or Guardian Signature