Park Cities Child and Family Counseling

4849 Greenville Ave Suite 1100, Dallas, Tx. 75206
214.886.5760 F. 214. 824.3777

CONSENT FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

Client: _____ **DOB:** _____

We are asking that you authorize the persons or agencies named below to disclose to each other confidential information regarding the above named student/client.

_Park Cities Child and Fmaily Counseling__ _____
Name of Person/Agency **Name of Person/Agency**

Address: 4849 Greenville Ave Suite 1100 **Address:** _____
Dallas Tx. 75206 _____

Phone: 214 886 5760
Cell:_____ **Phone:**_____
Fax: _214 824 3777 **Fax:**_____
E-Mail: _____

Records to be Released/Disclosed:

_____Recommendations / Observations

_____ Other _____

Please check the appropriate boxes below.

☐ ☐ **I have been fully informed in my native language or other mode of**
Yes No communication and understand the school/agency request for my consent as described above. This information will be disclosed upon receipt of my written consent.

☐ ☐ **I understand that my consent is voluntary and may be revoked at any**
Yes No time. However, I understand that revocation is not retroactive (i.e. it does not negate an action that has occurred after consent was given and before the consent was revoked).

☐ ☐ **I give my permission for the identified records to be released/disclosed**
Yes No to the above named person(s)/agency(ies).

_____ _____
Signature of Parent/Guardian **Date**