DEBBIE GROSS, LCSW, Ltd.
3255 N. Arlington Heights Road • Suite 502 • Arlington Heights, IL 60004
Phone: (847) 253-5352 • Website: www.debbiegrosstherapy.com

AUTHORIZATION FOR RELEASE OF CLIENT INFORMATION TO PARENT(S) BY MINOR AGED 12-17

Patient Name:	Address:
Date of Birth:	City, Zip:

I give my permission for the following information to be shared with my parent(s)/guardian(s) as listed below:

Mother/Guardian:	*Cell Phone:*	*Email:*
Father/Guardian:	*Cell Phone:*	*Email:*

☐ Full Consent: To communicate directly with my therapist about all treatment, treatment planning, session details, school functioning, behavioral interventions, medication management or any other treatment issues.

☐ Partial Consent: To communicate directly with my therapist specifically regarding treatment goals, medication management or behavioral interventions.

☐ Limited Consent: To communicate directly with my therapist only to the extent of my positive or negative participation in the counseling process and medication management.

I understand that care is taken to preserve confidentiality with me, a minor client, and to refrain from disclosure of information to my parent or guardian that might negatively affect my treatment. I also understand that if my therapist determines my intentions or behaviors to be at risk of harm to myself or others, confidentiality laws do not apply, and she will act in accordance with my best interest to seek help from my parents or other adults to create a safety plan for me.

My records are protected under HIPAA laws and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it and that in any event this consent expires automatically as described below.

Date:	Authorization valid through:
Client Signature:	
Witness Signature:	

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