A Team Of Independent Practitioners Providing Psychological, Educational & Organizational Services

Release of Information for Minors

I, _____ for _____
(PARENT/GUARDIAN) (MINOR CLIENT NAME AND DOB)

authorize

_____
(NAME/AGENCY)

_____
(ADDRESS/PHONE/FAX)

to ☐ **exchange** ☐ **release** ☐ **receive** information from my records with:

Shirley A. O'Neil, M.Ed., LCPC
Jefferson Street Counseling & Consulting
1517 W. Jefferson • Boise, Idaho 83702 • 208-385-0888

This release is authorized for the purpose of:

☐ Counseling and therapy (treatment coordination and planning)

☐ Other _____

Any information gained or released will be used in compliance with the client.

This release is in accordance with Federal Confidentiality Regulations as expressly defined in Part 2 of Title 42. It can be revoked at any time and will expire at such a time as authorized under these regulations.

Parent/Guardian's Signature: _____ Date: _____

Client's Signature: _____ Date: _____

Witness' Signature: _____ Date: _____