



Between Two Homes®, LLC

www.childreninthemiddle.com

Office (800) 239-3971

Fax (972) 704-2912

Support@childreninthemiddle.com

INSTRUCTIONS

This form allows the parenting facilitator to consult with other professionals as needed. Please leave the “I HEREBY GIVE MY PERMISSION FOR _____” blank, as this is where the professionals name will be added. Please complete the bottom portion, have a witness sign it and forward it with the rest of the packet information.



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CONSENT FOR RELEASE OF INFORMATION

PRINTED NAME OF INDIVIDUAL: _____

NAME(S) OF CHILDREN: _____

I HEREBY GIVE MY PERMISSION FOR _____ TO RELEASE AND DISCUSS ANY CHILD CARE, INVESTIGATIVE, MEDICAL, PSYCHOLOGICAL, PSYCHIATRIC, SOCIAL, CHILD SUPPORT, VOCATIONAL, AND/OR EDUCATIONAL INFORMATION CONCERNING MYSELF OR MY CHILDREN . I UNDERSTAND THIS REQUEST FOR INFORMATION INCLUDES MY CONSENT FOR RELEASE OF INFORMATION ON ILLEGAL DRUG USE, DISEASES, ILLNESSES INCLUDING HIV/AIDS, AND ANY TESTING ON MYSELF OR MY CHILDREN.

THIS INFORMATION MY BE RELEASED TO BRADLEY S. CRAIG, LMSW-IPR, CFLE FOR THE PURPOSE OF PARENTING FACILITATION.

I UNDERSTAND INFORMATION USED OR DISCLOSED PURSUANT TO THIS AUTHORIZATION MAY BE SUBJECT TO REDISCLOSURE AND NO LONGER PROTECTED. I UNDERSTAND TREATMENT OR PAYMENT CANNOT BE CONDITIONED ON SIGNING THIS AUTHORIZATION

THIS AUTHORIZATION MAY BE REVOKED VIA WRITTEN NOTICE AT ANY TIME EXCEPT TO THE EXTENT THAT THE INFORMATION HAS BEEN RECEIVED AND INCORPORATED INTO THE WORK PRODUCT. THIS RELEASE IS EFFECTIVE FOR ONE YEAR FROM SIGNED DATE UNLESS OTHERWISE REVOKED.

SIGNED: _____ DATE: _____

PRINTED NAME: _____

WITNESS: _____

A PHOTOCOPY IS AS VALID AS THE ORIGINAL