ICFE
INSTITUTE FOR COUPLE & FAMILY ENHANCEMENT

AUTHORIZATION FOR RELEASE OF MENTAL HEALTH INFORMATION

I hereby authorize the ICFE and/or ICFE therapist named below to disclose the individually identifiable health information as described below, which may include psychotherapy notes. I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment for my health care will not be affected if I do not sign this form. I also understand that if I do not sign this form, federal and state law will prohibit ICFE and my ICFE therapist from releasing records regarding the treatment of me/my child to the designated Recipient.

I understand that if the recipient is authorized to receive the information is not a covered entity, e.g. insurance company or health care provider, the released information may no longer be protected by federal and state privacy regulations. If my therapist is practicing under clinical supervision, this authorization also includes the clinical supervisor named in my current Therapy Information and Consent to Treatment form.

_____

Print Client Name Date of Birth

Therapist Name: _____

Date(s) of service (if known): _____

Description and Direction of information to be released: (check all that apply)

____	Entire Record	_____ Evaluation Reports	_____From ICFE Therapist to named party
_____	Billing Records	_____Treatment Plan	_____From named party to ICFE Therapist
_____	Progress Notes		_____Between ICFE therapist and named party
____	Other: _____		

Description of the purpose of the use and/or disclosure: _____

_____

The individually identifiable health information described herein shall be released to:

Name: _____ Organization: _____

Address: _____

Phone/Fax: _____ Email:_____

I intend for this Authorization to remain in full force and effect until I revoke it in writing. Further, it is my intent that a copy of this Authorization shall have the same effect as the original.
I further understand that I may revoke this authorization at any time by notifying the ICFE and/or my ICFE therapist in writing at 21015 Market Ridge, Suite 101, San Antonio, TX 78258. I also understand that the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

_____ _____

Signature of Client or Client's Representative Date

_____

Printed Name of Client or Client's Representative

_____ _____

Relationship to Client or Legal Authority (attach supporting documentation)