571-309-7993 | Fax 800-387-5701
www.koehnconsulting.com | Koehndj2@gmail.com
8359 Beacon Boulevard, Suite 315 | Fort Myers, Florida 33907

RELEASE OF CONFIDENTIAL INFORMATION CONSENT FORM

I, _____
(Client, Parent, Guardian or Legal Representative's Name)

hereby authorize and request that D J Koehn Consulting Services Inc.

☐ Bi-Directional Release (sharing) ☐ Release to ☐ Receive from

_____Relevant mental health, medical, educational, or legal information

_____Billing & Scheduling Information

Name:_____

Phone:_____ Fax:_____

List any information that you do **not** wish to disclose_____

Regarding: _____My child (child's name): _____
_____Myself

This information will be used to facilitate treatment and/or evaluation of myself or my child.

This authorization shall remain in effect until (check one):

____ Treatment/assessment has been completed
____ Date: _____
____ Event: _____
(fill in an event that relates to the individual or the purpose of the use or disclosure)

I understand that I may revoke this authorization, in writing, at any time by sending such written notification. I also understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and is no longer protected by HIPAA Privacy Rules.

_____ _____
Signature of Client Date

_____ _____
Signature of Parent, Guardian or Legal Representative Date