

**Centers for Family Change: School Treatment Notification**

Dear \_\_\_\_\_:  
(Address/phone/fax)

This letter includes a release of information giving the Centers for Family Change and yourself permission to discuss a student who has just begun therapy at the Centers for Family Change.

Patient: \_\_\_\_\_ DOB: \_\_\_\_\_  
Date of First Appointment: \_\_\_\_\_  
Next Appointment scheduled for: \_\_\_\_\_

**Patient reported problems with:**

_____ depressed mood	_____ peer/social difficulties
_____ anxiety	_____ attention problems
_____ underachievement	_____
_____ disruptive behavior	_____

**Diagnostic Impression:**

**This patient will be participating in:**

_____ Individual therapy	_____ Play therapy
_____ Family therapy	

**Additional Comments:**

Please contact me if you have any questions or additional information that you believe is important about this student/patient.

Sincerely,

\_\_\_\_\_  
Therapist signature

\_\_\_\_\_  
Date

Centers for Family Change

Main phone: 630-586-0900 ext. \_\_\_\_\_

SchoolreleaseformRevisedJune2011/cffcforms

Centers for Family Change: 2907 Butterfield Rd., St. 240, Oakbrook, IL 60523

Phone: 630 586-0900; Fax 630 586-9990

**Centers for Family Change: School Treatment Notification, p. 2.**

**Authorization to release and request information:**

I hereby consent to have the **Centers for Family Change** release \_\_\_\_\_ (initial) and/or obtain \_\_\_\_\_ (initial) information regarding (patient's name) \_\_\_\_\_, DOB, \_\_\_\_\_,

To/from my school: \_\_\_\_\_.

I consent to disclosure of/request for the following specific information:

- |  |  |
|--|--|
| _____ Entire Treatment Plan                                      | _____ Treatment Notes & Initial Assessment |
| _____ Psychological Testing Report                               | _____ Treatment Plan & Progress            |
| _____ School Records (including IEP, test reports and 504 Plans) |  |
| _____ Other (specify) _____                                      |  |

This disclosure is for the purpose of coordination of care. I understand that this consent can be revoked at any time by submitting a written and dated notice of revocation. I understand that Centers for Family Change (and its employees) cannot be held liable for any disclosures authorized by this release that occurred prior to the date of revocation.

I understand that unless revoked by written notice, this authorization of information is valid and binding for one year from the date signed.

Signature of client: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of others (those 12 or over who attended sessions): \_\_\_\_\_

Witnessed by: \_\_\_\_\_ Date: \_\_\_\_\_

This message is intended only for the individual (or entity) to which it is addressed and may contain information that is privileged, confidential and exempt from disclosure under federal law. If the reader of this message is not the intended recipient, you are notified that any distribution or copying of this communication is prohibited. If you have received this communication in error, please notify me immediately by telephone or fax. Thank you.

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