

Confidentiality Information

Consent for Release of Confidential Information

Many times, members of the same family will work with different therapists of the *Families by Design* team. It is our policy that the therapists supervise and review family cases with each other so that, as therapists, we are working together to create the best results for your family. Cases will be reviewed/consulted/supervised under Dr. Laurie M. Emery License #MH6296 and the rest of the FBD staff.

I, _____ (Patient's Name), understand and agree to the supervision/consultation of family cases by the professional therapists of *Families by Design, PA*. I authorize the disclosure of information regarding myself and my family members, for the sole purpose of making professional assessments for my family. _____ Initial)

(Only fill out if you want FBD staff to speak with an outside source)

There are situations where *Families by Design, PA*, may work in conjunction with an outside source, such as a patient's school or physician. The patient will be informed and asked permission before any information is released. It is always and only in the interest of the patient, that information is shared.

I, _____ (Patient's Name), understand and agree to Families by Design, PA., disclosing information, with my permission, to _____ (outside source) for the sole purpose forwarding my therapeutic/personal development goals.

I understand that my records are protected under federal and state confidentiality regulations and cannot be released without my expressed written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time, in writing, except to the extent that action has been taken in reliance on it (i.e. Probation, Parole) and that in any event this consent expires automatically as described below. I understand that the person or agency requesting this information may not transfer any information it may receive without obtaining written permission to do so.

Patient's Printed Name

Patient's Signature

Date

Parent/Guardian Printed Name

Parent/Guardian Signature

Date

