**Russell E. Hendlin, LMFT**

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**CONSENT FOR RELEASE OF INFORMATION (minor and family)**

I hereby authorize the release and exchange of information between Russell Hendlin, LMFT and

|  |  |
| --- | --- |
| Person or Organization name | Phone |
|  |  |

Regarding treatment of the following child(ren):

|  |  |
| --- | --- |
| Name | Date of Birth |
|  |  |
|  |  |
|  |  |
|  |  |

Information may also be shared about other family members listed below as it relates to treatment:

Unless specifically limited below, this release is for any or all information in your records. This release will remain in effect for one year or until \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, unless specifically revoked in writing prior to that time.

Purpose of this release is for treatment, coordination and:

|  |
| --- |
|  |

Limitations (if any):

|  |
| --- |
|  |

Authorized by (children over 12 must sign):

|  |  |  |
| --- | --- | --- |
| Client/Parent name | Signature | date |
|  |  |  |
|  |  |  |
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