Bright Futures Family Counseling

Authorization for the Release of Records for A Minor

Patient Name:_____**Date of Birth:**_____
(Also list maiden name/other names used if applicable)

I hereby request and authorize:

Bright Futures Family Counseling
1400 Preston Road – Suite 400
Plano, TX 75093 - 972-665-9835 Phone 972-665-9915 Fax

___X____To Disclose information to: **___X____To Receive Information from:**

Provider:_____

Address:_____

City/State/Zip_____

Information to be disclosed include copies of:
_____Entire Record
_____Progress Notes
Other: _____

This authorization will be effective for one year after the date signed, unless cancelled in writing. I understand that the cancellation will have no effect on information released prior to receiving the cancellation. A copy of this authorization is as valid as the original.

If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law.

_____/_____Date:_____
Signature of Legal Representative/Relationship

_____
Notice to recipient of information: This information has been disclosed to you from confidential records, which are protected by law. Unless you have further authorization, laws may prohibit you from making any further disclosures of this information without the specific written consent of the patient or legal representative.