

AUTHORIZATION FOR RELEASE/EXCHANGE OF RECORDS OR INFORMATION

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I understand that my records are protected under federal and state regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this authorization by writing the word "Revoke," my signature, and the date across this form at any time after signed, except to the extent that action has been taken in reliance on it. I also understand that permission to release family records must come from all members of the family age 18 or over participating in the services, or information released must be restricted only to information regarding the person/s who signs the release on behalf of her/himself or a minor child of whom they have legal rights to consent for treatment. If not previously revoked, this authorization will automatically expire one year following completion of services with this provider.

I authorize the parenting coach, **Loretta Maase, M.A.,**

To disclose information to: **AND/OR** To obtain information from:

All attorneys involved in this case, as identified by court records

My attorney:	_____	_____	_____
	name	phone	fax
My therapist:	_____	_____	_____
	name	phone	fax
My child/ren's therapist:	_____	_____	_____
	name	phone	fax
Other (GAL):	_____	_____	_____
	name	phone	fax

Client name [please print]

signature

date