SEOUL COUNSELING CENTER
FINDING THE STRENGTH TO OVERCOME

Authorization for Exchange of Information

1. The Center is required to protect my health information from being shared with third parties without my permission. By signing this document, I authorize the Center to share pertinent records and information acquired in the course of evaluation and/or treatment of_____ with the following persons and/or organizations: **(Child's Name)**

   Name of person(s) with whom the Center may share my info:_____

   Name of Organization (e.g., Company, School) with whom the Center may share my info:_____

   Contact information (phone number/email) of person(s)/organization:_____

2. I authorize the Center to share information with any caregivers who are involved in my child's care as well as any designated emergency contacts in the event of a medical or psychiatric emergency.

3. I understand that my authorization to release personal information as noted above is voluntary, and that I may refuse to sign this authorization. I also understand that the Center will not withhold assessment or treatment based on whether I sign this authorization.

4. I also understand that I may revoke this authorization at any time.

5. It is the policy of the Center to disclose information only to doctors, individuals, or agencies as authorized by me. However, I also understand that if the Center discloses information to an authorized party, that this authorized party could possibly re-disclose the information to another party, and that this subsequent disclosure would be no longer protected by the present authorization.

I understand that if I have any further questions about this authorization, I may ask them now.

Child's Name: _____

Parent/Guardian's Name (Print):_____

Parent/Guardian's Signature: _____

Relationship to Child: _____

Today's Date: _____

Consent State Date: _____

Consent End Date: _____