HopeWise

1931 NW Military Hwy #206
San Antonio TX 78213
(210) 617-3185
www.hopewisesa.com

Client Name: _____

Date of Birth: _____

By signing below, I authorize HopeWise to

☐ release to ☐ obtain from ☐ exchange with

Name and contact info for Agency

_____

_____

the following information pertaining to myself/my child:

☐ treatment summary ☐ history/intake ☐ diagnosis ☐ psychological test results

☐ psychiatric evaluation ☐ medication history ☐ dates of treatment/attendance

Other (specify)

_____

for the purpose of

☐ evaluation/assessment ☐ coordinating treatment efforts

Other (specify)

_____

I understand I have the right to refuse to sign this form, and that I may revoke my consent at any time (except to the extent that the information has already been released).

This consent is subject to revocation by the undersigned at any time except to the extent that action has been taken in reliance heron, and if not earlier revoked, it shall terminate on December 31 of this year without express revocation.

This may include aspects of treatment, progress, impressions by my counselor, reports on my/my child's wellbeing and my mental health medical history with the persons listed above. This information may be

released orally or in writing. I authorize that HopeWise may give information as my clinician deems appropriate for my care and that HopeWise may receive information for the same purposes from these same people.

Client Signature

Date