



In-Home Psychological Services
for Kids and Their Families

Release of Information

1409 S. Lamar #848, Dallas, TX 75215

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CHILD'S NAME: _____ DATE OF BIRTH: _____
First Name Last Name

I _____ (parent, or legal guardian) of _____ (child's name)

give permission to Treehouse In-Home Psychological Services to release my child's records to:

_____ (name of agency records are to be released to).

These records will be kept confidential and will be held in accordance with state and federal laws regarding the confidentiality of such records and information. However, records will be released regardless of consent under the following circumstances:

1. All cases of physical and sexual abuse or neglect of a minor or elderly person will be reported to the appropriate agency.
2. All cases in which there is a danger to self or others will be reported to the appropriate agency.
3. If a patient is in need of emergency services, appropriate emergency personnel will be contacted.
4. All records subpoenaed by the court will be released.

I hereby give permission to Treehouse In-Home Psychological Services to release my child's records to:

for follow-up, treatment, and continuity of care. Copies of reports are to be utilized by professional personnel only. Any information released to others will require interpretation.

By signing the release of information, the client acknowledges that he or she has had the above information explained and translated. Your signature below indicates agreement to have information released to the agency listed above.

Signature of parent or legal guardian

Date

Relationship

Witness

Date