



& 4 Real Solutions 4 Real Problems

Participant Name: _____

Information To Be Released or Exchanged with Anger Management Staff

Member/Facilitator:

Name: _____ Your relation: _____

Address: _____

Information To Be Released or Exchanged:

- Attendance Record
- Participation
- Anger Management Modality (Class or Executive Coaching)
- Number of Court-ordered sessions
- Parole
- Probation

Department of Child Family Services

Discharge Summary

Court/Agency Documents

Consultation

Treatment Plans

Educational-Tests and Reports

Progress Notes

Other (specify) _____ This

authorization shall become effective immediately and expire in one year. A scanned copy, photocopy, or fax of this form is to be considered as valid as original. Authorization of disclosure of your mental health information to someone who is not legally required to keep it confidential may be redisclosed and may not be protected.

Your Rights:

1. You may refuse to sign this authorization.
2. You have the right to revoke this Authorization by writing to your therapist, Anita Avedian. Your revocation will be effective when Anita receives it. This revocation, however, will not extend to information that was already obtained or released prior to the revocation.
3. You can receive a copy of this Authorization.

Participant Signature

Date