

CHILD AND FAMILY EMPOWERMENT SERVICES, LLC

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"Where empowerment leads to healthy prevention"

Counseling Service-Authorization for Release of Confidentiality

Client Name:

I authorize Child and Family Empowerment Services, LLC and the person or entities below, or their representatives, to mutually release and disclose my health information. I have received and reviewed Child and Family Empowerment Service Notice of Privacy Practices form, I understand that by signing this general authorization I am authorizing Child and Family Empowerment Services to disclose my health information in the possession of the person and entities listed below may be disclosed to the Child and Family Empowerment Services, my health information includes, without limitation, any record, report, test results, opinions assessments, and any other information relating to medical, emotional, education or psychological conditions. Discloser may also be made to describe my condition and progress and to discuss treatment.		
I understand that the information used or disclose under this authorization may be subjected to re-disclosure by the recipient, and may no longer be protected by Child and Family Empowerment Services, Confidentiality Rules.		
I waive any rights of privacy that may have in conis only valid until/ or until three Services.		
Insurance Company	Address	Client Initial
Name	Address	Client Initial
Name	Address	Client Initial
Client Signature	Date	
Name of Parent/Guardian (If Client is under 18)	Date	
Witness	Date	