Collaborative Team
Authorization for disclosing/receiving information

I, _____ authorize the following individual to disclose and receive information about me for the purpose of collaborative consultation:

Name Parenting Coordinator	Phone Number
Name Mother's Attorney	Phone Number
Name Father's Attorney	Phone Number
Name Guardian ad Litem	Phone Number
Name Mother's Therapist	Phone Number
Name Father's Therapist	Phone Number
Name Child's Therapist	Phone Number
Name Reunification Therapist	Phone Number
Name Other Member of Collaborative Team	Phone Number

I understand that I am giving my permission to the above-named individuals to use, disclose and/or request confidential information until the authorization ends (1year from date of signature unless otherwise specified). I have the right to revoke this authorization at any time, but it is not retroactive to information already released in accordance to the authorization. The person who receives the records to which this authorization pertains may not re-disclose them to anyone without my separate written authorization.

This authorization begins on _____ and expires on _____.

Signature of client or parent/guardian	Printed Name
Client Date of Birth	Date Signed
Witness	