School Treatment Notification: from Centers for Family Change

To: _____
(Phone/fax/address for school)

From: _____, of the **Centers for Family Change**

Attached is a release letter from one of your students.

This letter includes a release of information, giving the **Centers for Family Change,** and yourself, permission, to discuss this student. It also includes a brief summary of our assessment and treatment plan.

Please contact me if you have additional information that would be relevant to our treatment of this student, or if you have any questions about the treatment plan.

Sincerely,

_____
Centers for Family Change
630 586-0900 ext: _____
www.centersforfamilychange.com
email: cffcfamily@sbcglobal.net

Main phone: 630 586-0900
Business office phone: 630 586-9991
Fax: 630 586-9990

Centers for Family Change: 2625 Butterfield Rd., St. 101N, Oakbrook, IL 60523
Phone: 630 586-0900; Fax: 630 586-9990

Treatment Notification/Release, p. 2.

Dear: _____
(Phone/fax/address for school):

Your student, _____, is currently in treatment at the **Centers for Family Change,** and has signed this release allowing us to exchange information.

Authorization to release and request information:

I hereby consent to have the **Centers for Family Change** release _____ (initial) and/or obtain _____ (initial) information regarding
_____, SS # _____ DOB, _____,

To/from my school, _____.

I consent to disclosure of/request for the following specific information:

_____ Entire Treatment Plan
_____ Psychological Testing Report
_____ Treatment Plan and Progress
_____ Other (specify) _____

____ Educational/Academic Records
____ All Special Education Records
____ All School Records

This disclosure is for the purpose of coordination of care. I understand that this consent can be revoked at any time by submitting a written and dated notice of revocation. I understand that Centers for Family Change (and its employees) cannot be held liable for any disclosures authorized by this release, that occurred prior to the date of revocation.
I understand that unless revoked by written notice, this authorization of information is valid and binding for one year from the date signed.

Signature of client: _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____

Signature of others (those 12 or over who attended sessions):
_____.

Witnessed by: _____ Date: _____

Centers for Family Change: 2625 Butterfield Rd., St. 101N, Oakbrook, IL 60523
Phone: 630 586-0900; Fax: 630 586-9990

Student: _____: Date of birth: _____

Clinical Information:

Reason for referral/Presenting problems:

Diagnosis:

Treatment plan:

Current psychotropic medication (list):

Special Concerns (if any):

Please contact me if you would like additional information or have any information you believe I should be aware of.

Centers for Family change Therapist: (print) _____

Signature: _____ Date: _____

Phone: 630 586-0900; ext ____.

TREATMENT UPDATE

Progress to date:

New concerns/issues/changes in diagnosis:

Centers for Family Change Therapist: _____ (Print Name)

Signature: _____ Date: _____

Centers for Family Change: 2625 Butterfield Rd., St. 101N, Oakbrook, IL 60523
Phone: 630 586-0900; Fax: 630 586-9990