WAIVER OF PRIVELEDGE

I, ____, hereby authorize Milestone Counseling,

205 Hatteras Ave. Ste. 105 Clermont Fl. 34711 and its staff to:

__________ Release To _______ Release from _______ Exchange Written and/or Oral Communication

_______ Psychiatric _______ Medical ________ Law Enforcement

_______ Psychological _______ Counseling ________ State Agency

From the records of: ____ ____________________

Name of Client Date of Birth

To: ____

____

For the purpose of: ❑ Outpatient Counseling ❑ Coordination with schools ❑ Consultation with attorney

❑ Send Thank You Card for Referral ❑ Coordination with Family Members/Guardians

❑ Coordination with Healthcare Providers

❑ Coordination with Agencies

I understand that under state and federal confidentiality provisions only the above specified information can be released to only the above specified person or agency. I also understand that I may revoke this release of information at any time, providing that I notify the authorized agency in writing to this effect, but that revocation has no effect on action previously taken.

This consent will expire on __________________________________

Client, Parent, Guardian ______________________________________ Date ___________________________

Witness ____ Date ___________________________