Family &
Youth Institute, LLC

"We offer creative solutions for today's challenges."

Circle name(s) of Family & Youth Institute LLC therapist(s) authorized to communicate and accept information:

Mary Ann Sartori, M.A., LPC-S, LCDC-I
President

Jennifer Burns, M.S., LPC-Intern

Lindsay Gentles, M.A., LPC-Intern

Sandy Robinson, M.A., LPC-Intern

Sarah Yerelian, M.A., LPC-Intern

Denise Sartori-Garcia, M.A., LMFT, LPC
Vice President

Yesenia Y. Rios, M.A., LPC, NCC

Laura Henderson, M.Ed., LPC

Connie Hoagland, M.Ed., LPC

Amanda Koenig-Reed, M.A., LMFT

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION
for

Client:_____ DOB:_____

Authorization expires on (date) _____.

I hereby request and authorize Family & Youth Institute LLC therapist [name(s) designated/circled on the left] to communicate with and accept information from Primary Care Physician listed below:

YES_____ NO_____

THIS IS NOT A REQUEST FOR RECORDS. THIS IS A CONTINUITY OF CARE COMMUNICATION TO YOU THAT THIS CLIENT IS BEING SEEN IN THIS OFFICE.

Name:

Address:

Contact Information:

*Disclosure may include records that have information regarding diagnosis and treatment of psychiatric disorders but is/are not limited to these areas. To the party receiving this information: This information has been disclosed to you from records for which the confidentiality may be protected by Federal law. If so, Federal regulations (42CFR, Part 2) prohibit you from any further disclosure of it without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations.

Message to Physician:

DX:

_____ _____
Patient/Guardian Printed Name Witness Printed Name

_____ _____
Patient/Guardian Signature Witness Signature