WIDE HORIZONS FOR CHILDREN

Release of Counseling Information

This form must be completed by therapists who have treated any member of your household (including children) in the last five years.* Make as many copies as needed and mail to relevant professionals. Submit a copy of each form with your application materials so we will know to whom you have mailed a release.

To be completed by patient/client. *(Please print or type)*

Adoptive Parent(s) Name(s): _____

Patient Name: _____ Date of Birth: _____

Address: _____

Therapist Name: _____

Address: _____

Phone Number: _____

I hereby authorize Wide Horizons For Children, Inc., to release or obtain any and all relevant inforation from my therapist. Consent given by *(please sign)*: _____

To be completed by therapist. *(Please print or type)*

Treatment Start Date: _____ Treatment End Date: _____

Presenting Problem: _____

Diagnosis (include Axis I-V): _____

Medications: _____

Prognosis: _____

Hospitalizations/Treatment Centers *(list dates)*: _____

Check if there has been a history of any of the following:

☐ Child Abuse	☐ Suicidal Ideation/Attempts	☐ Physical Abuse
☐ Alcohol Abuse	☐ Drug Abuse	☐ Other
☐ Depression	☐ Marital Conflict	
☐ Poor Impulse Control	☐ Sexual Abuse	

If no longer in treatment, was ending treatment a mutual decision?: ☐ Yes ☐ No

If no, please explain: _____

Would the patient's current mental health condition prevent them from being a capable parent?:

☐ Yes ☐ No

If yes, please explain: _____

Please use the back of this page, or attach a page to expand on your comments and concerns regarding the adoptive placement of a child.

Signature of Therapist: _____ Date: _____

Print Name: _____

Address: _____ Phone Number: _____

Please return to: Wide Horizons For Children, 144 Moody Street, Building 24, Second Floor, Waltham, MA 02453

*WHFC reserves the right to request additional information.