**Authorization / Permission / Release**

**Insurance Authorization - *(Including Insurance)*  N/A**

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my counselor to submit claims for all benefits, for services to be rendered, without my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

 **Signature**:

**Client Group Confidentiality Statement N/A**

Problems and issues of a client that are discussed in group therapy are not to be discussed with anyone outside the group environment without specific written permission of that patient.

By initialing this document you have agreed to abide by this statement and you understand this statement.

 **Signature:**

**School Release N/A**

Date:

To Whom It May Concern: I am the legal guardian for

whom is a student at your school. I am requesting that services be allowed to take place during school hours with El Paso. The Counselor or Case Manager with El Paso will show photo identification. If you have any questions, please feel free to contact El Paso at 602-388-4017.

 **Signature:**

Witness Date/Time

**Emergency Medical Care for Minor N/A**

Date:

If I cannot be reached, I give my permission for El Paso to authorize emergency medical treatment that a physician deems necessary for the welfare \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. El Paso is limited to authorize emergency care only.

 **Signature:**

Witness Date/Time