Release of Information

Janna Flower, MA LPC

Request/Authorization to Release Confidential Records and Information

Name	DOB

I, the above listed, hereby authorize: Janna Flower, MA LPC to exchange written and/or verbal information regarding mental health, psychiatric, psychological, substance abuse, and other clinical issues, on behalf of myself/my child with the following recipient:

Name		Attn:
Address		
Phone	Fax	Email

Information to be exchanged includes: (please check all applicable boxes

- □ History
- □ Opinions
- □ Diagnosis
- □ Progress/Attendance
- □ Records
- □ Treatment Goals

and/or _____

For the purpose of: (please check all applicable boxes)

- □ Treatment Planning/Coordination
- □ Evaluation
- □ Medication Management
- □ Research
- □ Billing

and/or _____

HIV-related information and drug and alcohol information contained in these records will be released under this consent unless indicated here: □ **Do not release**

I have had explained to me and fully understand this request/authorization to release records and information, including the nature of the records, their contents, and the consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may take back this consent at any time by written request, except to the extent that action based on this consent has already been taken. This consent will expire automatically after 1 year from the date on which it is signed, or upon fulfillment of the purposes stated above.

I, the undersigned, would like a copy of this form □ Yes □ No

_____ _____ _____

Signature Printed name Date