

AUTHORIZATION TO RELEASE/REQUEST INFORMATION

Client Name \_\_\_\_\_  
\_\_\_\_\_

**Kelly Johnson may ( ) release information to (individual, agency name):**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Checkmark information to be released:  
\_\_\_\_ Opening Summary      \_\_\_\_ Summary of Treatment Progress  
\_\_\_\_ Psychiatric/Medical  
\_\_\_\_ Final Diagnosis      \_\_\_\_ Medications, Prescriptions, & Diagnoses  
\_\_\_\_ Treatment Plan  
\_\_\_\_ Closing Summary      \_\_\_\_ Attendance/Involvement in Treatment  
\_\_\_\_ Physician Notes  
\_\_\_\_ Discharge Summary      \_\_\_\_ Substance Abuse  
\_\_\_\_ Other  
(Specify) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Kelly Johnson may ( ) request information from (individual, agency name):**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Checkmark information to be released:  
\_\_\_\_ Opening Summary      \_\_\_\_ Summary of Treatment Progress  
\_\_\_\_ Psychiatric/Medical  
\_\_\_\_ Final Diagnosis      \_\_\_\_ Medications, Prescriptions, & Diagnoses  
\_\_\_\_ Treatment Plan  
\_\_\_\_ Closing Summary      \_\_\_\_ Attendance/Involvement in Treatment  
\_\_\_\_ Physician Notes  
\_\_\_\_ Discharge Summary      \_\_\_\_ Substance Abuse

\_\_\_\_ Other  
(Specify) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**This information is released/requested for the following purpose:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I certify this request is voluntary and the information above is accurate to the best of my knowledge. I may revoke this authorization in writing at any time, except when actions have already been taken to comply with it. I understand there is always a potential for re-disclosure by other parties involved. Re-disclosure of records without express written consent is prohibited. This authorization expires as follows (check one): \_\_\_one year from date of signature, \_\_\_the following date: \_\_\_\_\_, or \_\_\_is valid for the duration of treatment. A photocopy or facsimile of this release is as effective as the original. I hereby release the above parties from any liability that may result from furnishing this information.

Client Signature \_\_\_\_\_  
Date \_\_\_\_\_

Therapist Signature \_\_\_\_\_  
Date \_\_\_\_\_