

**John A. Henry, MA, LPCA**  
*Licensed Professional Counselor Associate*  
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**Authorization for Release and Exchange of Information with John Henry, MA, LPCA**

I, \_\_\_\_\_ (DOB \_\_\_\_\_), hereby authorize the release and exchange specified below between **John Henry, MA, LPCA** and:

Name of other person: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Fax: \_\_\_\_\_

Purpose of the disclosure authorized (as specific as possible):

Coordination of Care     Referral     Payment     Other \_\_\_\_\_

Data may be released in written, verbal, or electronic form and may include copies of the following information: **(Please check all applicable information)**

- Psychiatric Evaluation /Diagnosis Codes
- Psychological/Educational Testing
- Service/Treatment Plan
- Alcohol or Substance Abuse History and Tx
- General Progress in Treatment
- Discharge Summary
- Other: \_\_\_\_\_

This doctrine of authorization of release has been explained to me and I understand the contents to be released, the need for the information, and that there are statutes and regulations protecting the confidentiality of authorized information. I hereby acknowledge that this authorization is truly voluntary. This consent is subject to revocation by written instructions of the undersigned at any time. Further, I understand that this consent shall expire and must, if needed, be re-obtained twelve (12) months from the date below.

\_\_\_\_\_  
Client Name (Print)

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
John Henry, MA, LPCA

\_\_\_\_\_  
Date