John A. Henry, Jr., MA, LCMHC
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Authorization for Release and Exchange of Information with John Henry, MA, LCMHC

I, _____ (DOB_____), hereby authorize the release and exchange specified below between **John Henry, MA, LCMHC** 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, LCMHC Date