Jordan L De Jong, LPC

Emmaus Family Counseling Center

Authorization for Release of Information

I hereby authorize _____ to:

Release to ___ Exchange/consult with _____ Receive from _____

_____

(name of person, agency or organization)

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

The following information: _____

____ Treatment summary ____ Test Results/Reports/Summary

____ Dates of Therapy Services ____ School Reports/Records

____Progress Notes ____Verbal Communication

____ Other: _____

This information will be used for the following purpose(s):

____ Assessment ____Treatment ____Other: _____

This consent will automatically terminate in one year unless done so earlier by the client in writing. I understand the potential advantages and disadvantages, if any, of releasing this information. I understand that treatment services are not contingent upon my decision to sign this release.

Client:_____ Date: _____

Signature

Client:_____

Printed Name

Witness: _____ Date: _____

Attention: Persons, Agencies, or Institutions to whom this information is disclosed are prohibited by Federal Law from disclosure without written consent of the person to whom the information pertains.