KellyJohnstonCounseling.com
Jaye@KellyJohnstonCounseling.com

Consent for Release of Confidential Information

Client: _____ DOB:_____

I _____, voluntarily authorize the reciprocal release of confidential information
(Printed Name of Client

between Kelly-Johnston Counseling, PLLC (Jaye Kelly-Johnston, MA, LPC-S, CMS-CHT,FIBH

And _____
(Facility/Organization/Individual Releasing Information)

_____ _____
Mailing Address and or Email Address Phone Number

For the purpose of:

Continuity to care	Legal proceedings	Treatment planning
CPS Consultation	Residential placement	Continuation of Assessment
Psychiatric consultation	Psychological testing	Coordination of Treatment
Other:_____		

Information to be disclosed:

Diagnostic Impressions	Clinical Impressions	Progress Notes
Mental Status Exam	Psychiatric History	Psychological Assessment
Treatment Plan	Consultation	Discharge Summary
Other:_____		

Information to be released:

Verbally	Written	Verbally and/or Written

I understand that I may revoke this consent at any time except to the extent that action has already been taken, in reliance hereon, if not revoked sooner in writing. This consent will expire one year from the date signed.

I, the undersigned, do understand that the records to be released may include information regarding HIV, AIDS, mental health and psychiatry, drug dependence/abuse and or alcohol dependency/abuse treatment. I

To the receiving party of this information: This information has been disclosed to you for the sole purpose stated in this consent. Any other use of this information without the expressed written consent of the client or guardian is prohibited. These records are protected by Federal Regulation (42 CFR Part 2).

_____ _____
Client or Guardian Signature Date