Khristina Williams, LMHC, LPC, PLLC
CONSENT FOR RELEASE OF INFORMATION

Client Name _____ Birth date _____

I authorize the exchange of information with: ☐Primary Care Physician ☐School ☐Other
(check only **one** – **use separate release for each**)

_____ _____
Person/Agency Address

_____ _____
City State Zip Phone Number

I authorize (**Please Initial**):

___ Receive information <u>from</u> above named person/facility

___ Release information <u>to</u> above named person/facility

<u>NOTE</u>: I will only release documents originated From my office

I authorize the release of the following information (**Please Initial**):

___Social, medical, school or psychological reports ___ Medications used in treatment

___Treatment goals and/or progress ___ Results of court proceedings

___Information about drug and/or alcohol abuse ___ Other _____

___ HIV/AIDS

The purpose or need for the disclosure of information is:

__ Treatment planning/ongoing treatment ___ Diagnosis and evaluation

__Other _____

I voluntarily consent to the release of the above information, including drug and/or alcohol and psychiatric treatment information.

This consent may be revoked at any time except to the extent that action has been taken on it prior to revocation. This consent, unless earlier revoked in writing, will expire one year from the date of signature or on _____ (whichever is first).

_____ _____
Client Name Date

_____ _____
Parent/Guardian Signature (Relationship to Client) Date

_____ _____
Witness Signature (Relationship to Client) Date