Kindred Counseling Center
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Release of Information Consent Form

I, _____ (Client), authorize Meghan Jerry, LMFT, CST (Therapist) to:

☐ receive **and** release **any** information regarding my case
☐ release **any** information regarding my case
☐ release information regarding only the following: _____

release information via the following methods: ☐ **any** ☐ phone ☐ email ☐ mail ☐ fax

This information may be exchanged as indicated above with the following:

Name (Agency/Contact Person)		
Street Address, City, State, Zip		
Phone Number	Email	Fax

Purpose:

☐ To improve assessment & treatment planning, share info relevant to treatment, and coordinate treatment services when appropriate.
☐ Plan for and provide referral, assessment, ongoing treatment or medical care.
☐ To obtain insurance, employment, social services, or government benefits.
☐ To enable judges, attorneys, and/or probation/parole officers to support treatment or make legal decisions on my (or my child's) behalf.
☐ To coordinate treatment with my family or concerned person or agency.
☐ To coordinate treatment with my school, employer, or EAP representative.
☐ Other: _____

Client Consent and Agreement

I understand that I am not legally required to consent to this release of information and that I do so voluntarily for the purpose(s) stated above. This authorization will remain in effect until the conclusion of services (case closure), unless I revoke it in writing before that time. I understand that I may revoke this consent at any time in writing, except to the extent that action has already been taken based on this authorization. I understand that I am entitled to a copy of this document. I certify that the contents of this document have been fully explained to me, and I have chosen to proceed with this authorization voluntarily.

_____	_____	_____
Printed Name of Client	Signature of Client	Date