



Release of Information Consent Form

I, \_\_\_\_\_ (Client), authorize Meghan Jerry, LMFT (Therapist) to:

- receive 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:

I understand that by law, I do not need to consent to this release of information. I do so willingly and voluntarily for the purpose(s) specified above. The duration of this consent will be for one (1) year or at case closure, whichever comes first. I understand that I may revoke, in writing, this consent at any time, except to the extent that action has already been taken. I understand that I am entitled to a copy of this document. I certify that this document has been explained to me and that I understand its contents.

Printed Name (Client or Parent/Guardian) Signature of Client Date
Printed Name, Age (Minor) Signature of Minor Date