ERJ COUNSELING

Elizabeth Reeder Johnson, MSW, LCSW
Child, Adolescent, Family & Couples Therapy

Release of Information Form

I, _____, the undersigned, hereby authorize the following therapist (Elizabeth R. Johnson) to release and provide to:

Name:_____

Address:_____

Fax: (_____)_____-_____ with copies of documents as may be listed below. I acknowledge that I understand the purpose of the request and that authorization is hereby granted voluntarily.

Patient Information:

Name (Last, First, Middle): _____

Address: _____

Phone: (_____)_____-_____ Date of Birth (mm/dd/yy):_____/_____/_____

Requested Information or Documents:
[ ] History and Background Information
[ ] Psychotherapy notes
[ ] Diagnosis
[ ] Other (Please explain in detail): _____
_____
_____

NOTE: I understand that this release is valid for a period of one year (365 days). I further understand that I may cancel or revoke this authorization at any time in writing.

By my signature below, I consent to the release of the above listed information / documents.

Client's Name: _____

Client's Signature: _____ **Date:** _____

Parent/ Conservator's Signature if Client is a Minor _____ **Date:** _____