Promoting Positive Change, LLC
through individual, couples, & family therapy

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AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

A. CLIENT INFORMATION

Client's Name: _____ Client's Date of Birth: _____/_____/_____

B. AUTHORIZATION, INFORMATION TO BE RELEASED, AND PURPOSE OF RELEASE

By signing this form, I (name), _____, authorize Dr. Snell-Johns to release confidential information about me or the person listed above (for whom I serve as the legal guardian/ representative). I authorize Dr. Snell-Johns to release such information to:

_____

Person/Agency

_____

Address and Phone/Fax Number

I authorize release of the following confidential information:
____ *Any and all* information included in the case file/records or otherwise known to Dr. Snell-Johns
____ Specific information limited to the following:_____

_____

The purpose of this release (i.e. sharing of information) is to:

_____

_____

Unless I request otherwise, I understand this Authorization remains in effect for a year beyond the date it is signed. I have the right to revoke, or end, this Authorization by providing Dr. Snell-Johns with a written request to end the Authorization. Any such revocation would be effective upon receipt of such a request.

C. ACKNOWLEDGEMENT OF RECEIPT

I have read this form (or had it read to me) and understand the terms of this Authorization. I have had an opportunity to ask questions about the release of confidential information. I understand I can refuse to sign this Authorization.

_____ _____
Signature of Client or Client's Legal Representative Date Signed

_____ _____
Signature of Witness Date Signed