KATHLEEN JOSEPH
& ASSOCIATES LLC.

AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

This form cannot be used for the re-release of confidential information provided to Kathleen Joseph & Associates, LLC by other individuals or agencies. Such requests should be referred to the original individual or agency.

I, ______________________________, on ______________________
(TODAY'S DATE)

hereby authorize Kathleen Joseph & Associates, LLC and its staff to:

[ ] DISCLOSE INFORMATION TO **[ ] RECEIVE INFORMATION FROM** **[ ] EXCHANGE INFORMATION WITH**

NAME(S): ______________________________ PHONE #: ______________________

NAME(S): ______________________________ PHONE #: ______________________

NAME(S): ______________________________ PHONE #: ______________________

NAME(S): ______________________________ PHONE #: ______________________

NAME OR AGENCY NAME:

____

ADDRESS: ____
STREET (APT #) CITY STATE ZIP CODE

REGARDING: ______________________________ CLIENT PHONE: ______________________
(CLIENT NAME – PLEASE PRINT)

NAME OR AGENCY NAME:

____

ADDRESS: ____
STREET (APT #) CITY STATE ZIP CODE

REGARDING: ______________________________ CLIENT PHONE: ______________________

NOTICE: This information has been disclosed from confidential records. Any further disclosure without the specific written consent of the person to whom it pertains exceeds the limits of this release. However, there are legal and ethical requirements that counselors take responsible action in those situations as prescribed by law 1) where there is danger of imminent harm to self or others, and 2) in the case of apparent child abuse.

KATHLEEN JOSEPH
& ASSOCIATES LLC.

CLIENT ADDRESS:

____

ADDRESS: ____
STREET (APT #) CITY STATE ZIP CODE

CLIENT DOB: ____________________ CLIENT UFID#: ____________________________

THE INFORMATION TO BE DISCLOSED IS:

[ ] DATES OF TREATMENT ATTENDANCE **[ ] PARTICULAR SESSION DATED __________ OR [ ] ALL SESSIONS**

[ ] SUMMARY OF TREATMENT

[ ] ALL TREATMENT RECORDS

[ ] OTHER (SPECIFY) ____________________________

THE PURPOSE OF THIS DISCLOSURE IS FOR THE PURPOSES OF:

[ ] FURTHER TREATMENT

[ ] EVALUATION/ASSESSMENT AND/OR COORDINATING TREATMENT EFFORTS

[ ] DECISION TO TERMINATE THERAPY

[ ] OTHER (SPECIFY)

____

____

____

This consent is effective on ______________________ and expires on ________________.

This consent will automatically expire one (1) year after the date of my signature as it appears below, or on the following earlier date, condition, or event ______________________.

At this date or event, I understand that an additional Authorization of Release/Exchange of Confidential Information must be submitted to extend the disclosure.

My signature indicates that I approve of this disclosure. I also understand that I may revoke this consent at any time by giving written notice to the person or organization making this disclosure.

________________________________ ________________________________
CLIENT NAME (PRINTED) CLINICIAN NAME (PRINTED)

________________________________ ________________________________
CLIENT NAME (SIGNED) TODAY'S DATE CLINICIAN NAME (SIGNED) TODAY'S DATE

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