Consent for the Release of Confidential Information
for Jason Rhoads, LPC, LLC

I, _____,
authorize
(Name of Client)

(I HEREBY REQUEST AND AUTHORIZE)

____ TO RELEASE: ____ TO REQUEST FROM:

_____
(NAME)

_____
(ADDRESS)

_____
(CITY/STATE/ZIP)

_____ _____
(PHONE) (FAX)

CHECK APPROPRIATE AREAS TO BE RELEASED

__TELEPHONE CALLS/VERBAL COMMUNICATION
__CLINICAL ASSESSMENT
__PSYCHOSOCIAL HISTORY
__TREATMENT PLANS
__CONSULTATIONS
__DISCHARGE SUMMARY
__OTHER (PLEASESPECIFY):_____

__MEDDICAL INFO
__PSYCHIATRIC EVAL
__LAB RESULTS
__COURT/LEGAL DOCS

I FURTHER AGREE TO IDEMNIFY AND HOLD HARMLESS JASON RHOADS, LLC FROM ALL LIABILITY THAT MAY ARISE FROM THE RELEASE OF INFORMATION HEREIN REQUESTED.

I UNDERSTAND THAT THIS AUTHORIZATION IS SUBJECT TO REVOCATION IN WRITING.

_____ _____
DATE SIGNED SIGNITURE

_____
WITNESS SIGNITURE