Kindred Counseling Center
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Doylestown
350 S. Main St.
Suite 306
Doylestown, PA 18901

Release of Information Consent Form

I, _____ (Client), authorize Meghan Jerry, LMFT, CST (Therapist) to:

- ☐ receive **and** release **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