Release of Information
B Johnson LLC and Associates in Therapy
805 Walnut Street, Madison, IN 47250
Ph: 234-444-5055 Fax: 234-444-5467
www.bjohnsonllc.com

Client Information *(Subject of Release)* **Recipient Information:** *(Release To)*

Name:		**Name**	
DOB:		**Organization**	
Address		**Address**	
City		**City**	
State/Zip		**State/Zip**	
Phone		**Email**	
Email		**Phone**	
		Fax	

Terms of Release:

Please Check any/all information you would like to be released to the above identified those Identified with (*) must be checked to release this information per IC-16-32-2:

Request that an exchange of information be permitted between B Johnson LLC/Providers and the above identified recipient party or parties within the conditions identified below

Patient/Client request that release remain on file for ongoing and/or future identified use for an extent of 1 year or upon patient discharges from treatment revocation of release.

Patient/ Client request to terminate prior standing release of information to the above persons/ agency.

Please release the following content regarding the Client:

- ☐ Attendance/Compliance
- ☐ Discharge Summary
- ☐ Progress Status
- ☐ Recommendation/Referral
- ☐ Behavioral Health Assessment
- ☐ Psychiatric Diagnosis*
- ☐ Treatment Plan
- ☐ Substance Use History& Treat.*
- ☐ Trauma History
- ☐ HIV/STI Status*
- ☐ Psychotherapy Records*
- ☐ Genetic Records*
- ☐

Reason/Usage Terms ***(Purpose of release)***

- ☐ Personal Use/Client Direct Release
- ☐ Continuity of Care/Care Coordination/ Multidisciplinary Treatment and of Transfer/Referral to treatment
- ☐ For court or Legal use, Attorney/ Case Consultation
- ☐ Educational Planning/School-based Care
- ☐ Social Security/Disability Determination/Review

Other *Please describe the reason for release:*

I understand that I have the right to revoke this authorization at any time. In order to revoke this authorization, I must do so in writing and present my written revocation to the above-named authorized entity. The revocation will not apply to information that has already been released in response to this authorization. I understand that I am not required to sign this Authorization in order to receive health care treatment. Records may include records that it received from other organizations, other collateral information shared and stored within record will not be released as a part of release of records B Johnson, LLC or Bethany Johnson, LCSW cannot prevent redisclosure of your information by the person or organization who receives your records under this authorization, and that information may not be covered by state and federal privacy protections after it is released. By signing this authorization, you release B Johnson, LLC or Bethany Johnson, LCSW from any and all liability resulting from a redisclosure by the recipient.

☐ Client/Authorized Individual provided consent verbally via phone/email on: ______________________________

Signature: ____ Date: _______________

Authorization to release: *(Please Identify your authority to sign)*

Self/Client Named Parent/Guardian Power of Attorney Court Authority Given

For Office Use: *(Notes regarding release request)*