CONSENT FOR RELEASE OF INFORMATION

PATIENT NAME: _____DOB: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
PHONE: _____

This consent authorizes Jennifer Snow, MS, LPC, PLLC:
_____To release information regarding the above named patient to:
_____To gather information regarding the above named patient from:

Name: _____
Organization:_____
Address:_____
City: _____ State: _____ Zip:_____
Phone:_____Fax:_____

_____Entire Record _____Assessments _____Progress Notes _____Drug\Alcohol
_____Hospital Notes & Discharge Summary _____ HIV \ AIDS
_____Current Medications_____Other:_____

The purpose of this disclosure \ request is:
_____Coordination of care _____Treatment Plan
_____Other: _____

This consent may be revoked at any time by providing written notice. By signing this form the patient acknowledges that he \ she has been give information about what is to be disclosed\requested, the purpose of the disclosure\request, and who will receive the information. Signing this form also releases Jennifer Snow, MS, LPC, PLLC from any legal liability resulting from the release of this information. Consent for this disclosure will expire ninety days after termination of treatment with Jennifer Snow. The expiration may otherwise be set at the discretion of the patient for the following date:_____

Signature of
Patient/Guardian:_____Date:_____

Signature of Therapist:_____Date:_____