**Jennifer D. Nichols, MA, LPC-S**

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Authorization to Release Information

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ authorize Jennifer D. Nichols, MA, LPC-S and

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(name of person(s) or organization(s) which disclosure is to be made to and/or received from)

to disclose or release one to the other the following information from my records or from the records of my minor child:

\_\_\_\_\_\_\_\_ All Health Care Information

(Initials)

\_\_\_\_\_\_\_\_ Health Care Information or Opinions Relating to any or all of the following treatment(s) and, or (Initials) conditions:

 \_\_\_\_\_\_\_\_ 1) Psychiatric or Mental Health Information

 (Initials)

 \_\_\_\_\_\_\_\_ 2) Academic and Confidential School Information

 (Initials)

 \_\_\_\_\_\_\_\_ 3) Testing

 (Initials)

 \_\_\_\_\_\_\_\_ 4) Other

 (Initials)

For the purpose of treatment/management and or supervision or psychological and or medical condition(s),

**I hereby waive my right to the privileges of confidentiality as specified above, for a period of one year after termination of treatment, management or supervision unless expressly revoked earlier in writing.**

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Client’s Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent or Legal Guardian Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Date