



THE CLINIC @ THE MONTGOMERY

Dr. Jonathan Eric Carroll, KLPC, NCPC, NCCE,
ACPE Psychotherapist

AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

This form cannot be used for the re-release of confidential information provided to the Counseling Center by other individuals or agencies. Such requests should be referred to the original individual or agency.

I _____ authorize The Clinic @ The Montgomery, LLC., to:

_____ release to:

_____ obtain from:

_____ exchange with:

the following information pertaining to myself or my dependent:

_____ treatment summary

_____ history/intake

_____ diagnosis

_____ psychological test results

_____ psychiatric evaluation/medication history

_____ dates of treatment attendance

_____ other (specify) _____

for the purpose of:

_____ evaluation/assessment and/or coordinating treatment efforts

_____ other (specify) _____

This consent will automatically expire one (1) year after the date of my signature as it appears below.

I understand I have the right to refuse to sign this form, and that I may revoke my consent at any time (except to the extent that the information has already been released).

Signature of Client

Date

Signature of Witness

Date