Authorization to Release/Request Confidential Information

Benjamin J. De Nooy, M.A., NCC (under the supervision of Jennifer J. Jackson, M.A., LPC) and Jennifer J. Jackson, M.A., LPC (under the supervision of Joannie DeBrito, Ph.D., L.M.F.T) are hereby authorized to ( ) release/ ( ) request all confidential medical, psychological, psychiatric, educational, and/or other appropriate information from the client record of:

_____ DOB:_____
Client's Name

Please ( ) release information to/ ( ) request from:

_____

_____

_____
(Name, phone number, and address of clinician, agency, school, or institution)

The release of this information is only for the purpose of:

_____

_____

The consent is voluntary and may be revoked at any time by written notice to all the above parties or by the change in guardianship or custody.

The following signed hereby releases the above parties from any liability, which may result from providing this information.

_____ _____
Signature of Client Date

_____ _____

Signature of Parent or Guardian Date