**Jennifer Morris Mental Health Counseling, LLC**
17344 W 12 Mile Rd, Suite 209
Southfield, MI 48076
Telephone: (248) 923-1408
Fax: (248) 327-7152

## AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

Client's Name & Address _____
_____
_____

Date of Birth _____

I, _____, hereby request and authorize

____ Jennifer Morris Mental Health Counseling, LLC
____ Other (Name and Address) _____
_____

to release to

____ Jennifer Morris Mental Health Counseling, LLC
____ Other (Name and Address) _____
_____

the following items

____ Entire Medical Record
____ Evaluation (Medical, Psychiatric) _____
____ School Record
____ Other (Describe) _____

in the following formats

____ Verbal
____ Written
____ Fax
____ Other (Describe) _____

in order to

____ Facilitate evaluation/treatment.
____ Provide for continuity of service.
____ Other (Describe) _____

This consent for release of information shall terminate _____. (If no date specified, consent is valid for one year). If there is a charge for this service, I agree to pay it. A photocopy of this release shall carry the same force as the original. I understand that I have the right to revoke this consent by notifying Jennifer Morris Mental Health Counseling, LLC.

Signature _____ Date _____

Relationship to Client: Self/Parent/Legal Guardian (circle)

Telephone _____

Witness _____ Date _____