Joanna Carson-Young, M.A., Licensed Marriage and Family Therapist, #80858

Consent to Exchange Information

Client Name:_____ **Birthdate:**_____

I, _____ and/or_____
(Name of client) (Name of Parent or Guardian)

authorize_____ to disclose or exchange
(Receiving/Releasing Person or Agency)

information to_____, with the knowledge that such
(Receiving/Releasing Person or Agency)

contact discloses that person named above is, or has been, receiving mental health services.

Disclosure of information is for the purposes of assessment, evaluation, or treatment planning.

Information disclosed will be limited to the following:

1. _____Diagnosis
2. _____Psychiatric History
3. _____Psychosocial History
4. _____Medical Information, including results of exams and/or tests
5. _____Results of Psychological Testing
6. _____Legal Information
7. _____Other:_____

This consent is subject to revocation by the undersigned at any time. This consent expires one (1) year from the date it was signed or when the undersigned terminated counseling services, whichever comes first, unless alternate date is given here:_____
(Expiry Date)

_____ _____
(Signature of Client) (Date)

_____ _____
(Signature of Parent/Guardian) (Date)

_____ _____
(Signature of Therapist/Authorized Person) (Date)

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