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JMV THERAPY

AUTHORIZATION FOR RELEASE OF INFORMATION

Client Name: _____ Date of Birth: _____

Social Security #: _____

I, _____ authorize Jake Voelker, MA, LMFT to
(Client's Name)

☒ release and/or ☐ exchange information with:

Name: _____ Relationship: _____
(i.e., Doctor, Therapist, Psychiatrist, etc.)

Address: _____
City, State, Zip: _____
Phone #: _____ Fax #: _____

Purpose for Release of Information:
☐ Personal ☐ Continuation of services ☐ Billing ☐ Legal
☐ Other, please explain: _____

Information requested:
☐ Medications ☐ Intake / DA ☐ Telephone consultation
☐ Other: _____

I understand that the information requested will be released and shared with the third party written above. I understand that I have a right to revoke this release of information at any time. I understand that this authorization will remain in effect a maximum of twelve months from date of signature and may be cancelled by me in writing at any time. A photocopy of this authorization will be treated in the same manner as the original.

Signature of Client: _____ Date: _____

Signature of Parent or Guardian *(if applicable)*: _____ Relationship: _____