JEN MCVANN, MS LMFT CST

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Authorization to Release Confidential Information

I authorize Jen McVann, MS, LMFT, CST, to release the following information obtained during the course of treatment for _____ to:

(Client Name)

Person/Agency: _____

Address: _____

Phone: _____ Fax: _____

This authorization permits the release of following information (check all that apply):

- ☐ Any and All Information Necessary
- ☐ Verbal Exchange
- ☐ Summary of Care
- ☐ Diagnostic Assessment
- ☐ Treatment Plan
- ☐ Medication Information (current)
- ☐ Psychological Testing Results
- ☐ Appointment Information
- ☐ Other: _____

_____ I agree HIV status and/or drug/alcohol usage may be disclosed.
(Initials)

This information will be used for the following purpose (check all that apply):

- ☐ Treatment
- ☐ Care Coordination
- ☐ Insurance
- ☐ Litigation
- ☐ Other: _____

I understand that I have a right to receive a copy of this authorization. I also understand that any cancellation or modification of this authorization must be in writing. This authorization shall remain valid for one year or until discontinuation of services.

_____	_____	_____
Client – Print Name	Client – Signature	Date
_____	_____	_____
Parent/Guardian (if minor) – Print Name	Parent/Guardian (if minor) – Signature	Date