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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