Release of Confidential Information

Julian & Associates
Psychotherapy Services
4403 1st Ave SE, Suite #314
Cedar Rapids, IA 52402
319.382.4720

Release From: *Nashae (Nikki) Julian,* PhD, LMHC, ACS

Release to:

Name ____

Phone:____

Address: ____

Email:____

The purpose of this release is to allow the above parties to release information about me, which is necessary for the development and support of my therapeutic goals. This can include diagnosis, treatment plans and progression, evaluation information, medical and psychological information and any information that is pertinent and necessary for the progression and support of my therapeutic goals.

Your signature below will allow Nikki Julian to share private information and release my diagnosis and mental health record to the above person and/or agency.

I understand that I may revoke this consent in writing at any time. I understand that I may review the information that is released. I understand that any release which has been made prior to my revocation and which was made in reliance upon this authorization shall not constitute a breach of my rights to confidentiality. This authorization will automatically expire one year from the date of signature, except as specified ______________________ (specify number of days or months). At that time, no express revocation shall be needed to terminate my consent.

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED
BY FEDERAL AND STATE LAW

If information of the following types is available I give permission for its release:(Patient must initial appropriate lines.)

	Yes	No
1. Substance Abuse	____	____
2. Mental Health	____	____
3. HIV/AIDS Related Information	____	____

____
Patient Signature   Date

____
Counselor Signature   Date

In order for the above information to be released it must be signed.