Release of Confidential Information

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Julian & associates
PSYCHOTHERAPY SERVICES

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

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.