



SHANNON JOHNSON LPC
PSYCHOTHERAPY

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RELEASE OF INFORMATION

I (_____) hereby voluntarily consent to the release of any and all written and verbal information that pertains to the clinical assessment, diagnosis, and current treatment of _____.
Client name

Shannon L. Johnson, LPC is authorized to consult with the following individual(s):

name/title	phone	fax
_____	_____	_____
_____	_____	_____
_____	_____	_____

I understand I have the right to revoke my consent at any time, and will inform the above parties in writing should I wish to do so.

_____	_____
client signature	date
_____	_____
signature of parent or guardian	date