(972) 824-0803
shannon.johnsonlpc@gmail.com
www.shannonjohnsonlpc.com

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