Authorization To Release Information

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This form is devised to protect the rights to confidentiality. Please note that the form specifies with whom information about you may be exchanged, the nature of the information, and the purpose of the information. All blanks should be filled in before you sign. If you have any questions about the form and how it is used, please ask.

I_____
(Print Name)

Authorize Dr. Brian Jensen, Ph.D., To Discuss and/or Exchange Confidential

Information With_____

In Regard To (Whom)_____

Nature or Extent of Information_____

_____

Purpose of Information Exchange_____

I understand that I have a right to receive a copy of this authorization. I also understand that I have a right to cancel or modify this authorization at any time, but that change must be in writing.

This Is Valid From Date Signed But Not Beyond_____

Signature_____ **Date**_____
(Parent if in Regard to a minor)

Brian Jensen_____ **Date**_____

Any information you authorize other persons to release will not be released to others without your written permission. Any information you have authorized to release is limited to the purpose and party stated above. It may not be released to a third party.

Licensed Marriage Family Therapist (MFC 40118)
Licensed Professional Clinical Counselor (LPCC 806)
Certified Clinical Mental Health Counselor (57654)
Certified PTSD Clinician (15879)
National Board Certified Counselor (57654)