PDJ PSYCHOTHERAPY & CONSULTING, INC.

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AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

I, _____ hereby authorize Patricia D. Johnson, Psy.D., LMFT
(Patient's Name)
to release confidential information obtained during the course of my treatment to:

Name of Provider: _____

Telephone Number of Provider: _____

This Authorization permits the release of the following information:

_____ Any and All Information Necessary ( ) Please initial.

_____ Diagnosis _____ Treatment Plan _____ Prognosis

_____ Progress to Date _____ Clinical Test Results _____ Dates of Treatment

_____ Summary of Treatment

_____ Other _____

_____

I understand that my health information is protected by law. I authorize the release of my confidential health information as indicated above. I understand that my consent is voluntary and I can revoke this permission at any time, except to the extent that it has already been shared based on this authorization. Should I choose to revoke this authorization I will state this in writing.

By: _____ Date: _____
(Patient or Patient's Representative*)

*If signed by other than Patient, please indicate the relationship between Patient and his/her Representative:

_____