

PERMISSION FOR RELEASE OF INFORMATION

I, _____, hereby authorize the Counseling Center Staff of Johns Hopkins University located in Suite S-200, 3003 N. Charles St., Baltimore, MD 21218 (phone: 410-516-8278) to:

disclose information to receive information from exchange information with

Name(s): _____ Phone #: _____

Name or Agency Name: _____

Address: _____
(street) (city) (state) (zip)

Regarding: _____ Client Phone: _____
(Client Name – please print)

Client Address: _____
(street) (city) (state) (zip)

DOB: _____ SS#: _____

The information to be disclosed is:

- Attendance information
 - Summary of treatment
 - All treatment records
 - Withdrawal/Readmission recommendation
 - Other (specify) _____
- _____
- _____

The purpose of this disclosure is for:

- Further treatment
 - Withdrawal/Readmission process
 - Other (specify) _____
- _____

This consent is effective on _____ and expires on _____.

I understand that I may revoke this consent at any time by giving written notice to the person or organization making this disclosure.

Client Signature: _____ Therapist Name: _____

NOTICE: This information has been disclosed from confidential records. Any further disclosure without the specific written consent of the person to whom it pertains exceeds the limits of this release. (However, there are legal and ethical requirements that counselors take responsible action in those situations as prescribed by law 1) where there is danger of imminent harm to self or others, and 2) in the case of apparent child abuse.)