Footprints Counseling, PLLC
3410 Healy Drive 200-A
Winston-Salem, NC 27103
(336) 893-8727 / fax (336) 893-8726

CONSENT FOR THE RELEASE AND/OR EXCHANGE OF INFORMATION

Client Name: _____ **Chart Number:** _____

Date of Birth: _____

Therapist: **Joseph B. Alexander, LMFT**

I hereby give my permission for:

_____
Name of Agency, Hospital, Doctor or Individual

_____
Mailing Address

_____
City **State** **Zip**

_____ _____
Phone **Fax**

( ) to release to: **( ) to exchange with:**

Joseph B. Alexander, LMFT **of** **Footprints Counseling, PLLC**

Therapist

The following information from the clinical record for the period from _____ to_____:
(check items to be released)

( ) Intake Summary	**( ) Social History**	**( ) Psychological Eval.**
( ) Psychiatric Eval.	**( ) Treatment Plan**	**( ) Discharge Summary**
( ) Aftercare Plan	**( ) Other: _____**	**( ) All Information**

Concerning the above named client for the following reasons:

_____

_____
Write in reasons for release of information

I understand that this release may include information regarding the following drug abuse, psychological or psychiatric information.

I understand that the information to be released is protected under state and federal laws and cannot be redisclosed without my further written consent unless otherwise provided for by state and federal law. I understand that I may revoke this authorization at any time, expect to the extent that action has already taken to comply with it. Without my express revocation, this consent will automatically expire _____ days (or 1 year) from the date it is signed.

_____ _____
Date **Signature of Client**

_____ _____
Date **Signature of Parent Guardian, or Authorized Representative When Required**

_____ _____
Date **Witness**