Roger L. Johnson M.A., Th.M.
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Authorization/Consent For Release of Confidential Information

I,______________________________________, born ____________________, authorize Roger L Johnson, M.A.,Th.M.,LPC (2800 N. Dallas Parkway, Suite 220, Plano, Tx 75093) to disclose my/my child's records to the individual or group specified below:

☐ Hospital ☐ Psychiatrist (M.D.) ☐ Psychologist ☐ LPC, LPC intern

☐ Insurance Company ☐ Other______________________________________.

Contact Name: ____ Organization:_____________________________

Address: ____

City, State, Zip:____

The disclosure of records authorized herein is required for the following purpose:

☐ Court Subpoena ☐ Personal Review ☐ Therapist Consultation

☐ Insurance Reimbursement ☐ Other Care: ____

The following specific types of information are requested:

☐ All Records ☐ Records from _________(mm/dd/yy) to _________(mm/dd/yy)

This authorization shall remain in effect from ____________(mm/dd/yy) to ____________(mm/dd/yy)

I understand that I am giving consent for the release of my records from Roger L Johnson , M.A., Th.M., LPC only to/from the above named organization/person for the time shown above. I understand that, with a few limited exceptions, Roger L Johnson M.A.,Th.M.,LPC may not release records and/or information about myself/my child unless I agree to the request. I understand that I may look at the records and/or information to be released and that I may withdraw my consent at anytime in writing. I understand that I cannot withdraw consent for actions that have already taken place before I withdrew my consent. The information, which is being disclosed, is from records whose confidentiality is protected by Federal Law. Regulation 42-CRF Part 2 prohibits disclosure without the written consent of the person to whom it pertains.

____
Client Signature Date

____
Parent/Guardian Signature Printed Name Date

____
Witness Signature Printed Name Date

____
Staff Signature Date

2009 by Roger L Johnson M.A.,Th.M.,LPC