Judith Smithchild, LPCC-S
Licensed Professional Clinical Counselor, Supervising
17 Blue Line Drive, Athens, Ohio 45701
740-592-5689 - FAX 740-593-7166

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

The information below is pertaining to: _______________________________
DOB:_____________

I, authorize Judith Smithchild, LPCC-S, to contact: ____________________________

Address:
____
____
____

Phone: _____________________
Fax: _______________________

_ to release the following information:
- __ Assessment and Diagnosis
- __ Treatment
- __ Social History
- __ Psychological Test Results
- __ Other________________

_ to obtain the following information
- __ Assessment and Diagnosis
- __ Treatment
- __ Social History
- __ Psychological Test Results
- __ Other ________________

The purpose of such disclosure is for:
- __ Continuity of care
- __ Coordination of services
- __ Developing a treatment plan
- __ Other ________________

I am signing this consent voluntarily, understand that my records are confidential, and cannot be disclosed without my consent. The obtained released records will become a part of my permanent file at this office, and can be re-disclosed only with my consent unless legally mandated. I further understand that my refusal to authorize the release of information could negatively impact my psychological care. I have the right to inspect the information disclosed to Judith Smithchild, LPCC-S, and I have the right to receive a Notice of Privacy Practices for this office. Judith Smithchild, LPCC-S will receive no compensation for obtaining these records. I understand that I may revoke this consent at any time and that this consent expires on ______________.

Signature: __________________________ Date: ____________
Witness: __________________________ Date: ____________