Jessica Davidson

Licensed Professional Counselor | Child & Adolescent Therapy

Authorization for Release of Information

I authorize my counselor, Jessica Davidson, LPC-MHSP, to:

___ coordinate mental health treatment planning by phone or in person
___ give and receive clinical records to assist in treatment planning

This authorization allows Jessica Davidson to release information with:
_____

This authorization is effective from _____ until _____.

I understand that I can cancel this authorization at any time by contacting my counselor directly. I also understand that this de-authorization will be effective from the date I contact her to revoke this authorization through any future dates but does not affect any contact that was made with the above authorized person prior to the revoking of authorization.

_____ _____
Client's Signature Date

_____ _____
Parent/guardian's Signature Date

_____ _____
Therapist's Signature Date