Raleigh Teletherapy
Gate Healing, PLLC
Jonathan F. Anderson, LCMHC, LPC-Supervisor
Professional Consulting, Psychotherapy & Supervision
(919) 780-4357

Authorization to Release Confidential Information

I, _____, hereby release Jonathan F. Anderson, LCMHC, LPC-S to release confidential information.

This information will be released to:

Name: _____ Telephone: _____

Agency: _____

Address: _____

The purpose of this disclosure is: _____

_____

Information to be disclosed (please check all that apply):
_____Number of counseling sessions
_____Alcohol/Drug usage history
_____Summary of sessions
_____Client report of progress
_____Other (Please specify)_____

Method of releasing information: _____Telephone
_____Written/Fax

I am signing under the following conditions:

- My judgment is not impaired by emotional duress or any chemicals
- I may withdraw this authorization, in writing, at anytime.
- If not withdrawn, this authorization expires twelve (12) months from the date of signing.

_____ _____
Signature Date