



**Jo Raphael, LCSW, ACSW, BCD**

6100 Lake Forrest Dr., Suite 450, Sandy Springs, GA 30328

Phone: 404.291.9181

**Consent and Authorization for Release of Information**

If there are other parties that may assist in your therapy, and you believe it would be helpful for me, your therapist, to contact them regarding your treatment, please read carefully and complete this document.

The following is an authorization for the stated parties to consult with one another regarding your treatment process. Information shared is for the sole purpose of facilitating maximum care to you as the client. Please provide the necessary information, your signature and today's date.

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I, \_\_\_\_\_ (client/legal guardian), hereby authorize Jo Raphael, LCSW and the following party or parties to discuss my treatment, information and records obtained during the course of psychotherapy treatment including but not limited to diagnosis. Please list any person/entity you would like me to communicate with and list contact information (phone and/or email):

(1) Name \_\_\_\_\_ Contact Info \_\_\_\_\_

(2) Name \_\_\_\_\_ Contact Info \_\_\_\_\_

(3) Name \_\_\_\_\_ Contact Info \_\_\_\_\_

Please indicate your preference regarding the information to be shared:

\_\_\_\_\_ The parties stated above may discuss my medical and or mental health information without limitations.

\_\_\_\_\_ I would prefer to limit the information shared between the party stated above. The limitations are:

\_\_\_\_\_  
\_\_\_\_\_

The above named parties, therapist and person(s) or entity (entities) designated under (1) (2) and /or (3) agree to exchange information only between themselves (or their agents). Any disclosure of information extended beyond these parties is considered a breach of confidentiality.

Your signature below indicates that you understand that you have a right to receive a copy of this authorization. Your signature also indicates that you are aware that any cancellation or modification of this authorization must be in writing, and you have a right to revoke this authorization anytime unless the therapist stated above has acted in reliance upon it. Additionally, if you decide to revoke this authorization, such a revocation must be made in writing and received by Jo Raphael, LCSW.

NOTE: Treatment is not contingent upon you signing this authorization, and you have the right to decline to sign this release form.

Signature of client or guardian: \_\_\_\_\_ Date: \_\_\_\_\_