Release of Information

I, _____
(name)

_____
(address)

authorize
_____
(name/agency)

_____
(address)

to ☐ **exchange** ☐ **release** ☐ **receive** information from my records with:

Cheryle Jones Andrews , M.Ed., LCPC, LMFT
Jefferson Street Counseling & Consulting
1517 W. Jefferson • Boise, Idaho 83702 • 208-385-0888

This release is authorized for the purpose of

☐ Counseling and therapy (treatment coordination and planning)

☐ Other _____

Any information gained or released will be used in compliance with the client.

This release is in accordance with Federal Confidentiality Regulations as expressly defined in Part 2 of Title 42. It can be revoked at any time and will expire at such a time as authorized under these regulations.

Client's Signature: _____ Date: _____

Witness' Signature: _____ Date: _____