John T. Doheny III, LPC MAC
2901 University Ave., Suite 41, Columbus, GA 31907
*Licensed Professional Counselor * Master Addiction Counselor*
Phone 706-575-1833 Fax 706-507-9012

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, hereby authorize John T. Doheny III, LPC, MAC, to ***obtain from*** or ***release to:***

Name: _____

Address: _____

Street City State Zip

Phone: _____

Fax: _____

any information from my confidential records and any specific portion thereof as requested by me or deemed necessary for providing proper care for me. All information I hereby authorize to be obtained from or released to Mr. Doheny will be held strictly confidential and cannot be released by him without my written consent. Unless otherwise revoked, this authorization will remain in effect for the period necessary to complete all transactions related to services provided for me but no longer than one year from the date signed. I understand that, except to the extent that action has already been taken which was based on my consent, I may withdraw this consent at any time.

_____ _____
Client Signature Date

_____ _____
Parent or Legal Guardian for client under 18 years of age Date

_____ _____
Witness Date

Use This Space To Revoke Authorization

_____ _____
Date Authorization Revoked Client Signature