EMILY GRIFFIN, M.A., LCPC

Clarity Through Counseling, LLC
501 N. Frederick Ave, Suite 300 • Gaithersburg, MD 20877

Authorization to Exchange Information

This authorizes Emily Griffin, MA, LCPC to release information to another party.

I hereby authorize **Emily Griffin, MA, LCPC** to release information to:

Name: _____
Address: _____
Phone Number: _____
Fax: _____

Purpose of disclosure:
_____
_____
_____

Please check what Emily is allowed to disclose to the above party:
____ Diagnosis
____ Summary of Treatment
____ Progress in Treatment
____ Dates of Treatment
____ Treatment Plan
____ Full Treatment Record
____ Discharge Summary
___ Other _____

I understand that I may revoke this consent at any time except to the extent that action based on it has already been taken.

I understand that I am authorizing the disclosure of confidential information and agree that a photocopy of this authorization will be as valid as the original.

Client (or Guardian) Signature:_____

Print Name:_____

Date:_____