Carroll Counseling Center

Paul Carroll, LPC

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Consent to Release Information

I, _____, authorize **Paul Carroll, LPC** to release any medical information requested in written or verbal form to:

Name: _____

Address: _____

_____

Phone: _____

I understand that this information may include diagnosis, treatment plan, dates of scheduled procedures, progress, and medication prescribed. I may revoke this consent at any time except to the extent that action has been taken in reliance upon it, and that in any event this consent shall expire six months from the date of signature, unless another date is specified.

_____ _____

Signature **Date**