Davorka Marovic-Johnson, M.Ed., LPC

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RELEASE OF CONFIDENTAL INFORMATION

I, _____, authorize **Davorka Marovic-Johnson, M.Ed., LPC**:

Release to: ___ Obtain from: ____

Name/ Agency:_____

Address:_____

The following specific information:_____

I understand that my records are professional under the Federal Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time by notifying the authorized party with a **dated written revocation,** except to the extent that action has been taken prior to Notice of Revocation and that in any event this consent expires automatically as described below.

This permission is in effect from the date of this signature through 12:01 am of

_____ _____, 20____.

Month Day

Client's Signature: **Date:**

Therapist's Signature: **Date:**