Jess Albright, LCPC, ACS
Licensed Clinical Professional Counselor

Consent to Release Information

I, ____, authorize Jess Albright, LCPC, ACS, to _______ (Exchange), _________ (Provide), __________ (Receive) the following information about my treatment:

__________ Treatment summary or progress

__________ Attendance

__________ Other:

With the following person(s) or entities:

Name: ____

Address: ____

____

Phone: ____

Name: ____

Address: ____

____

Phone: ____

For the purpose of:

____

____

I understand that I may revoke this consent at any time by providing written notice. This consent is valid for one year.

________________________ ____________________
(Client Signature) (Date)

________________________ ____________________
(Clinician Signature) (Date)

124 N. Court Street, Frederick, MD 21701 240-457-9015
counselingwithjess@gmail.com www.counselingwithjess.com