Jess Albright, LCPC, ACS
Psychotherapist
124 N. Court Street
Frederick, MD 21701

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)