Julian R. Harris, MSW, LICSW
1633 Q Street NW, Ste 210
Washington, DC 20009
202-335-3119

Consent for Release of Information

At times, and for various reasons, clients sometimes find it beneficial when their "team" collaborates on their care. However, because all aspects of our therapeutic work together are strictly confidential (aside from in the situations outlined in the information and consent form), in order for me to be able to speak with any of your other providers or supporters (medical doctor, psychiatrist, family members, etc). I need your express, written consent. Please use the form below to indicate people, if any, with whom you would like for me to collaborate on your care. In addition to indicating the names and contact information for people with whom you would like me to collaborate or consult, please use the letter key on the following page to indicate what types of information you permit me to share with each person or entity. Please note that for clients under 18, a parent or guardian must complete this form to indicate other people or entities with whom they would like for me to collaborate.

Client Name: _____ **Client Date of Birth:** ____ /____ /____

Persons or entities with whom you consent for Julian R. Harris, LICSW to collaborate or consult:

1. Name: _____ **Relationship:**_____

Contact Information:

_____

Information to be disclosed (choose the letters that correspond to the type of information you consent to share)**:** _____

2. Name: _____ **Relationship:**_____

Contact Information:

_____

Information to be disclosed (choose the letters that correspond to the type of information you consent to share)**:** _____

3. Name: _____ **Relationship:**_____

Contact Information:

_____

Information to be disclosed (choose the letters that correspond to the type of

information you consent to share)**:** _____

A. Diagnosis **B.** Attendance **C.** Treatment Progress **D.** Clinical Test/Assessment Results

E. Prognosis **F.** Discharge Summary **G.** All/Any Information Requested

I understand that I have the right to amend or withdraw this consent form at any time and that I will receive a copy of this form as well as any amendments keep in my records. Unless amended or withdrawn, I am aware that this form will be valid until the 90 days beyond the end of my treatment with Julian R. Harris.

_____ _____ _____

CLIENT NAME (PRINT) CLIENT/PARENT SIGNATURE DATE