Marjorie R. Johnson, LCSW, PCC
610-696-4443
Marjorie@AscendConsulting.net

Ascend Consulting, Inc.
937 Pritchard Lane, West Chester, PA 19382
www.AscendConsulting.net
www.AscendCounselingPA.com

AUTHORIZATION FOR RELEASE
Regarding
USE OF CELL PHONE, E-MAIL, and VOICEMAIL COMMUNICATIONS

Date: _____

I, _____
First Name **Last Name** **Date of Birth**

Address _____

City _____ **State** _____ **Zip** _____

Telephone Numbers: _____

Email Addresses: _____ ,

Grant consent for my therapist **Marjorie Johnson, LCSW** to correspond with me via cell phone, e-mail, and the use of voicemail for the purpose of scheduling appointments for counseling or coaching, including treatment planning, diagnosis or conveying general information about my care or the services rendered. I understand that cell phone, e-mail, and the use of voicemail communications are not secure forms of communication and that confidentiality of any cell phone, e-mail, and voicemail information cannot be ensured.

Please be advised that e-mail and the use of voicemail are not to be used in order to communicate urgent matters or emergencies.

Please initial here to indicate you understand the above: _____

THIS AUTHORIZATION IS VALID THROUGHOUT YOUR TREATMENT PERIOD.
I understand that I may revoke this authorization at any time, but not retroactive to the release of information made in good faith, by writing to the above specified parties. I understand that information released by this authorization may be subject to re-disclosure by the recipient and may no longer be protected by Federal Law.

It has been explained to me that if I decline to consent to this release of information, the following are the consequences: Specify (if any): Limited treatment and communications.

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_____	_____	_____
Signature of Person Authorizing	**Date**	**Signature of Witness**

_____
Relationship to Client

[ ] ***I have chosen to receive a copy of this form***

[ ] ***I have chosen not to receive a copy of this form***