Jennifer Allen Norton, M.A., LPC-S

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CONSENT AND RELEASE OF INFORMATION

I authorize the sharing of pertinent information regarding my treatment with my physician, therapist, pastor, attorney, school official, agency, person, or any other therapist with whom I am currently in therapy.

Signature:____ **Date:**______________________

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Name of authorized person and their phone number.

Name:____ **Phone:**______________________

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I authorize Jennifer Allen Norton to share pertinent information regarding my treatment with any therapists, physicians, or treatment team with whom I might enter into treatment during the period of time I am in therapy with Jennifer Allen Norton.

Signature:____ **Date:**______________________

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Jennifer Allen Norton seeks consultation when appropriate with other professionals in the community. Ongoing consultation ensures the highest quality of therapy and treatment for clients, sustain professional development and prevent personal biases from hindering the therapeutic process. This consultation is essential to maintain the highest standards for your care. All legal and ethical confidentiality laws and standards apply during these professional consultations.

Signature:____ **Date:**______________________

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I understand that after the final session of counseling or in the event that I have not attended a counseling session in three months that the client/therapist relationship will be considered closed unless I initiate further contact.