If you give your permission for me to talk to anyone else about your care here, including acknowledgement that we know each other due to this therapeutic relationship, please complete this form.

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I,_____

Hereby authorize Shelley Shane, MA, MFT, to release and/or obtain from the following agencies and/or people:

_____
_____
_____
_____
_____

all information pertinent to coordination of care.

This information will be used to provide appropriate, coordinated treatment.

I understand that my records are protected under various regulations governing confidentiality and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that I may revoke this consent at any time by providing written notice, except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically one year after discharge date.

_____ _____

Signature of Client or Guardian Date