**Shannon Herman Consulting, LLC**

**Certified Professional Coach**

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**Consent to Release Information**

|  |
| --- |
| In some instances, consent to release information is necessary in order to provide the best possible care. Examples include present or past therapists, physicians or psychiatrists that may have treated you in the past, school counselors, teachers who are involved in your care, or parents. Information will be shared only if express permission is given in writing. Only information critical to the client’s care and current goals will be shared. |
|  |
| Client Name: Date of Birth:    By signing below, I hereby consent to the release of information to be shared between Shannon Herman Consulting, LLC and the below entity: |
| **Information may be shared for the purpose of (please check):** |
|  |
| \_\_\_\_ Coordination of Treatment Team \_\_\_\_ Planning |
| **\_\_\_\_** Coordination of Goals **\_\_\_\_** Coordination of services |
| Other: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| Name of Organization/Person: Relationship to Client: |
|  |
| Address: |
| Phone Number: |
|  |
| **Client / Guardian Signature:** **Date:** |
| **Shannon Herman, MA, CPC: Date:** |
| **\_\_\_\_\_\_\_\_ I will communicate with Shannon Herman Consulting, LLC in writing if I wish to revoke this form of communication.** |