Sherry Haslam, LCPC
Freedom Path Counseling, LLC
8100 E. 22nd St. N., Building 1500 A
Wichita, KS 67226
sherryhaslamtherapy@gmail.com
p (660)-722-0830/f (316)-330-4002

Authorization Consenting To Release Of Information

I,_____, authorize Sherry Haslam, LCPC to discuss (verbally or in writing) and to receive anything that has been brought up during psychotherapy or evaluation with any person/s or staff of clinic, office, agency, or institution/s named below:

1. Name: _____ Business:_____
   Phone: _____ Fax: _____ Email: _____
   Address: _____ City: _____ State: _____ Zip: _____

2. Name: _____ Business:_____
   Phone: _____ Fax: _____ Email: _____
   Address: _____ City: _____ State: _____ Zip: _____

For the following reason/s (check all that apply):

____ Consultation/Psychotherapy

____ Evaluation

____ Other: _____

I may revoke this consent at any time. This consent is in effect for five years from the date of the last session, unless revoked in writing earlier, renewed, or alternate date is listed here:_____. This consent is also subject to all conditions outlined in the Office Policies (listed in the Informed Consent Form).

Client/Guardian Printed Name	**Birthdate** ____/____/____
Signature	**Date** ____/____/____
Client #2/Guardian Printed Name	**Birthdate** ____/____/____
Signature	**Date** ____/____/____