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Authorization for Release of Confidential Information

Client's Name \_\_\_\_\_ Birth date \_\_\_\_\_

I, \_\_\_\_\_ and/or \_\_\_\_\_  
Name Name

Authorize \_\_\_\_\_  
Releasing Professional/Agency Phone #  
\_\_\_\_\_  
Address

To exchange information/records with Sheryl B. Hausman, Ph.D., with the knowledge that such contact discloses my services. The disclosure of information/records is required for evaluation, treatment planning, or for the following purpose:

\_\_\_\_\_  
\_\_\_\_\_

This consent is subject to revocation by the undersigned at any time. If not earlier revoked, this consent expires one year after the signature date.

Signed \_\_\_\_\_  
Client/Parent/Guardian Date  
  
\_\_\_\_\_  
Client/Parent/Guardian Date