Sharyn Schreiber Pinney, LCSW

Consent for the Release of Confidential Information

PLEASE PRINT

☐ **Authorization to Release Information to Health Care Professional**

I, _____ , hereby authorize Sharyn Schreiber Pinney,
Client's Name

LCSW, to disclose any necessary information obtained in the course of evaluation and/or treatment with

_____ for the following purpose:
Name of Provider/Organization

_____

_____

_____

☐ **Authorization to Request Information from Health Care Professional**

To assist in the evaluation and/or treatment of _____
Client's Name

I Sharyn Schreiber Pinney, LCSW, hereby request pertinent information for the purpose stated below, from:

_____
Name of Provider/Organization

Information Needed:

_____

_____

_____

The disclosure of this information is for the following purpose:

_____

_____

_____

Client Consent

I understand that this is subject to revocation by the undersigned at any time, except to the extent that the action has been taken in reliance hereon.

I further understand that my authorization to release information on my evaluation and/or treatment is not required when said information is ordered by a court of law.

_____ _____
Client Signature *Date*

_____ _____
Parent, Guardian, or Authorized Client Representative Signature *Date*