Sharon Drexler PsyD. LCSW

Authorization To Release Information

Date: _____

To: _____

Re: _____

I, _____ hereby authorize _____

_____ to obtain from or release to

_____

the following information from my records:

_____ Psychotherapy/Counseling Progress

_____ Psychological Evaluation

_____ Psychiatric Evaluation

_____ Neurological Evaluation

_____ Medical History/Evaluation

_____ School Reports

_____ Treatment Plan/Summary

_____ Hospital Discharge/Summary

_____ Information sharing with each other

_____Other

This information will used for the purpose of _____

This consent will begin the date of this Authorization and expire one year later,

_____, unless terminated by me in writing at any time prior to expiration.

I, the undersigned, hereby acknowledge that I have read this Authorization prior to its execution and full understand the nature of this release.

_____

Client's Signature