Balanced Choices
Shannon Hartman Wilson
MA, Clinical Psychology
LMFT, LPC, NCC

Client's Name_____

Birth Date_____ SSN_____

I consent to the release and exchange of all information between Shannon Wilson and the following persons and/or agencies:

Person(s)_____ Agency_____

Person(s)_____ Agency_____

Person(s)_____ Agency_____

Person(s)_____ Agency_____

This information includes psychiatric/psychological and medical information including alcohol and drug abuse or addition data from my health records.

All information released to Shannon Wilson will be used solely for assessment of, and planning for, client's needs and for developing a treatment plan to meet those needs.

This consent for release and exchange of information is valid until treatment is discontinued.

I understand that I have the right to refuse to sign this authorization and that Shannon Wilson is released from all legal liability that may arise from the release of the information requested. I understand that I may revoke this release, in writing, at any time, except to the extent that it has already been acted upon.

A fax or photocopy of this release is to be considered as valid as the original.

_____

Parent/Legal Guardian or Client Signature | Printed Name | Date

_____

Therapist Signature | Date