Consent to Release Information

I, the undersigned, give permission for Donna M. Firer, LCSW - C to discuss information regarding my care and treatment to the following individual:

_____

Name and Title/Relationship to Client

_____

Telephone Number (s)

_____

Mailing Address

Please Check one of the following:

1)_____ I understand that the information to be discussed will be limited to the following:

2)_____ I understand that the information to be discussed may include but is not limited to initial evaluation and history; therapy goals and progress, and termination summary.

The consent, unless revoked earlier, will expire one year from the date of signature.

_____ Date:_____

Signature of client/parent/guardian

_____ Date:_____

Signature of Therapist