David Shanley PsyD, LLC

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CONSENT TO RELEASE INFORMATION

In regard to the records of:

Name: _____ DOB: _____ SSN: _____

I _____, consent that David Shanley, Psy.D. may

___ Exchange **___Provide** **___Receive**

The following information about treatment:

___Treatment summary or progress **___Diagnosis**

___Attendance **___Other:** _____
_____
_____

With the following person(s) or entities:

_____	_____
Name/Agency	Name/Agency
_____	_____
Address	Address
_____	_____
City State Zip	City State Zip
_____	_____
Telephone	Telephone
_____	_____
Fax	Fax

For the purpose of: ___Continuation of Care ___Education Planning ___Legal

___Other: _____

I fully understand this authorization to release information and request to release or obtain records and information from my records at the nature of the records, their contents, the consequences and implications of its release, and my request is wholly voluntary on my part. I hereby release the source of these records from any liability arising from their release. I authorize the parties above to talk by telephone about my referral, diagnosis, treatment, and similar topics relevant to the above listed purpose for this release of records. I understand the provision of services is not contingent upon this releasing of information.

This "consent to release information" form is valid for one year, or as allowed by state law. I understand that I may revoke this consent at any time in writing except to the extent that action based on this consent has been taken.

_____
Print Name Date

_____
Signature