# 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