Joshua Shifrin, PhD, ABSNP, NCSP
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CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

I, _____
(Print Client, Parent, Guardian or Legal Representative's Name)

hereby authorize and request that Dr. Joshua Shifrin

■ Release to ■ Receive from ☐ Bi-Directional Release (sharing)

_____Relevant mental health, medical, educational, or legal information

_____Billing & Scheduling Information

Name:_____

Phone:_____ Fax:_____

List any information that you do **not** wish to disclose_____

Regarding: _____My child (child's name): _____
_____Myself

This information will be used to facilitate treatment and/or evaluation of myself or my child.

This authorization shall remain in effect until (check one):

____ Treatment/assessment has been completed
____ Date: _____
____ Event: _____
(fill in an event that relates to the individual or the purpose of the use or disclosure)

I understand that I may revoke this authorization, in writing, at any time by sending such written notification. I also understand that information used or disclosed pursuant to this authorization may be subject to be disclosure by the recipient and is no longer protected by HIPAA Privacy Rules.

_____ _____
Signature of Client Date

_____ _____
Signature of Parent, Guardian or Legal Representative Date