4 West Rolling Crossroads, Suite 3, Catonsville, Maryland 21228 • 443-292-6722 •shawna@HealASista.com •www.HealASista.com

CONSENT TO DISCLOSURE OF CLIENT RECORDS/INFORMATION

Client Full Name: _____
Date of Birth: _____
Social Security #: _____

☐ I, the undersigned, hereby consent to, direct and authorize **Shawna Murray-Browne, MSW, LCSW-C**, to release or disclose information to:

NAME:_____

ADDRESS: _____

_____

PHONE: _____

☐I, the undersigned, hereby consent to, direct and authorize:

NAME:_____

ADDRESS: _____

_____

PHONE: _____

to release information **TO Shawna Murray-Browne, MSW, LCSW-C,** at the address listed above.

This information should pertain to my medical, educational, psychiatric/drug/alcohol records, specifically:

☐ Outpatient Therapy All Prior episodes of Treatment

☐ A copy or the portion of the record pertaining to: _____

☐ Other: _____

For the following purposes:

☐ Facilitation of Assessment

☐ Coordination of Treatment and Support

☐ Monitoring Progress

☐ Coordination of Payment for Professional Services Rendered

☐ All of the above

☐ Other: _____

*I understand that I may revoke this consent at any time, except to the extent that action has been taken in reliance on it.This consent shall expire **12 months after the date of client termination** (unless another date is specified). For reimbursement purposes, this authorization shall remain in effect until full reimbursement for services has been received by this therapist.*

_____ _____
Client or Parent/Guardian Signature Date

_____ _____
Client Signature **(14 years old or over)** Date

_____ _____
Witness Signature Therapist Signature

THIS INFORMATION IS BEING DISCLOSED TO YOU FROM RECORDS WHOSE CONFIDENTIALITY IS PROTECTED BYLAW. FURTHER DISCLOSURE OF THIS INFORMATION, EXCEPT WITH THE SPECIFIC WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS, IS PROHIBITED BY LAW.