Cheryl Shive, M.S., MSW
Registered Psychotherapist
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AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

Client Name:_____

I hereby authorize Cheryl Shive, Registered Psychotherapist, to release and/or receive confidential information from: _____
_____

The authorized information may be released in verbal or written form, or by electronic transmission.

Type of information: Mental health/psychiatric/drug and alcohol assessment and treatment reports, medical records including diagnosis and treatment information and reports, and psychological evaluation reports and recommendations.

Purpose: This authorization includes information required for any of the following purposes:

- To facilitate psychotherapy
- To coordinate psychotherapy with medical recommendations/treatment
- To provide information for determination of benefits, utilization review, appropriates\ness of care, or other purposes deemed necessary to third party payers
- To provide a record of compliance with mandated treatment to employer, probation office or other:_____
- Other:_____

Release from liability: I understand that the information being released or received is or may be subject to federal or state regulations, and I hereby release Dr. Foxman and the individual or agency named above from any liability associated with release/receipt of such information. I understand that I may revoke this consent at any time by making such request in writing.

Expiration: This authorization shall expire one year from the last scheduled appointment.

_____ _____
Signature of Client or Authorized Representative Date