Cheryl Shive, M.S., MSW, LICSW

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AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

Client Name: _____

I hereby authorize Cheryl Shive 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.

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

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:

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