BONNIE K. SHINHEARL, M.Ed., LPCC
LICENSED PROFESSIONAL CLINICAL COUNSELOR
COUNSELING BY BONNIE

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AUTHORIZATION CONSENTING TO RELEASE OF INFORMATION

I, _____, authorize BONNIE K. SHINHEARL, LPCC to discuss and exchange, in verbal or written form, any relevant information relating to my treatment with the person or institution named below:

Name/Institution Name

Address

Phone Number

For the following reason(s)

_____coordination of care

_____Other:_____

You may revoke this consent at any time. Unless otherwise revoked or renewed, this consent is in effect for ONE YEAR from the date of last session.

_____ _____

Client/parent/ Legal Guardian Signature Date