

**Shawnesse Herbert, M.A., LPC-Intern
Supervised by Debbie Edmunds, MA, LPC-S**

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Authorization to Release Information

I, _____ authorize

Shawnesse Herbert, M.A., LPC-Intern
and

(name of person(s) or organization(s) which disclosure is to be made to and/or received from)

to disclose or release **one to the other** the following information from my records:

- _____
Initials All Health Care Information
- _____
Initials Health Care Information or Opinions Relating to any or all of the
following treatment(s) and, or conditions:
- _____
Initials 1) Psychiatric or Mental Health Information
- _____
Initials 2) Academic and Confidential School Information
- _____
Initials 3) Testing
- _____
Initials 4) Other _____

For the purpose of treatment/management and or supervision or psychological and or medical condition(s), **I hereby waive my right to the privileges of confidentiality as specified above, for a period of one year after termination of treatment, management or supervision unless expressly revoked earlier in writing.**

Patient

Date

Parent or Legal Guardian

Date

Witness

Date