Penny Spector-Shleifer, LCSW
License # 44SC05672500

CONSENT TO RELEASE OF INFORMATION AND CONSULTATION

I, _____, authorize disclosure and exchange of information between _____ and Penny Spector-Shleifer, LCSW, concerning my treatment. The purpose of this consultation is for therapeutic purposes only and will remain confidential between these two parties. This consent is subject to revocation in writing at any time and will expire automatically at the termination of my treatment.

_____ _____
SIGNATURE DATE

If you are giving permission for a minor child, sign below:
_____ SIGNATURE OF PARENT OR GUARDIAN
_____ _____
NAME OF CHILD DOB

PRINT NAME, ADDRESS AND PHONE NUMBER OF PARTY TO BE CONSULTED:
_____
_____
_____
_____