Stephanie E. Hernandez, LCSW
Licensed Clinical Social Worker

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CONSENT FOR DISCLOSURE OF INFORMATION AND RELEASE OF INFORMATION

Client Name: ____________________________________
Date of Birth: ____________________________________
Social Security Number: (optional)___________________

I hereby authorize Stephanie E. Hernandez, LCSW to disclose information or release records regarding my treatment with her to ___________________________________.

The specific purpose/need for disclosure of such information and/or records is:
____

The consent to disclosure may be revoked at any time, by giving written notice to do so, however, the revocation will not affect any action that has already been taken in accordance with the consent.

This consent shall become effective on ______________________________________
and unless revoked, will expire in six months or at the end of treatment.

____________________________________ ____________________________
(Signature of Client) (Date)

____________________________________ ____________________________
(Signature of Witness) (Date)