**Sheryl J. Frank, Ph.D.**

Licensed Psychologist

804 Pershing Drive, Suite 004

Silver Spring, MD 20910

 Tel: (301) 585-0859

Fax: (301) 585-0858

**AUTHORIZATION FOR RELEASE OF INFORMATION**

Client information:

|  |  |
| --- | --- |
| Name: | Click here to enter the client’s name |
| Date of Birth: | Click here to enter the client’s date of birth |
|  |  |

I hereby give:

|  |  |
| --- | --- |
| Name: | Click here to enter name |
| Address: | Click here to enter address |
| Phone number: | Click here to enter phone number |
|  |  |

permission to release the following information: (check those that apply)

|  |  |
| --- | --- |
| [ ]  Behavioral | [ ]  Therapeutic goals |
| [ ]  Emotional | [ ]  Therapeutic progress |
| [ ]  Cognitive | [ ]  Therapeutic treatment recommendations |
| [ ]  Other | [ ]  Academic functioning |

To:

|  |  |
| --- | --- |
| Name: | Click here to enter name |
| Address: | Click here to enter address |
| Phone number: | Click here to enter phone number |
|  |  |

for the purpose of facilitating consultation, therapeutic treatment, or psychological evaluations.

|  |  |  |  |
| --- | --- | --- | --- |
| Click here to type an e-signature |  | Click to select today’s date |  |
| Client or Legal Guardian |  | Date |  |