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**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:

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| --- | --- |
| Name: | Click here to enter name |
| Address: | Click here to enter address |
| Phone number: | Click here to enter phone number |
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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 |
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for the purpose of facilitating consultation, therapeutic treatment, or psychological evaluations.

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