



2526 St Paul Street Baltimore, Maryland 21218 • 443-292-6722 • Shawna@ShawnaMurrayBrowne.com

CONSENT TO DISCLOSURE OF CLIENT RECORDS/INFORMATION

Client Full Name: _____

Date of Birth: _____

Social Security #: _____

I, the undersigned, hereby consent to, direct and authorize **Shawna Murray-Browne, MSW, LCSW-C**, to release or disclose information to:

NAME:

ADDRESS:

PHONE:

I, the undersigned, hereby consent to, direct and authorize:

NAME:

ADDRESS:

PHONE:

to release information **TO Shawna Murray-Browne, MSW, LCSW-C**, at the address listed above.

This information should pertain to my medical, educational, psychiatric/drug/alcohol records, specifically:

- Outpatient Therapy
- All Prior episodes of Treatment

A copy or the portion of the record pertaining to: _____

Other: _____

For the following purposes:

- Facilitation of Assessment
- Coordination of Treatment and Support
- Monitoring Progress
- Coordination of Payment for Professional Services Rendered
- All of the above

Other: _____

*I understand that I may revoke this consent at any time, except to the extent that action has been taken in reliance on it. This consent shall expire **12 months after the date of client termination** (unless another date is specified). For reimbursement purposes, this authorization shall remain in effect until full reimbursement for services has been received by this therapist.*

Client or Parent/Guardian Signature

Date

Client Signature (14 years old or over)

Date

Witness Signature

Therapist Signature

THIS INFORMATION IS BEING DISCLOSED TO YOU FROM RECORDS WHOSE CONFIDENTIALITY IS PROTECTED BYLAW. FURTHER DISCLOSURE OF THIS INFORMATION, EXCEPT WITH THE SPECIFIC WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS, IS PROHIBITED BY LAW.