

**Shannon S. Herman, M.A.**  
**LICENSED PROFESSIONAL COUNSELOR**  
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**Consent to Release Information**

In some instances, consent to release information is necessary in order to provide the best possible treatment and care. Examples include present or past therapists, physicians or psychiatrists that may have treated you in the past, school counselors, teachers who are involved in your care, or parents. Information will be shared only if express permission is given in writing.

By signing below, I hereby consent to the release of information to be shared from Shannon S. Herman, M.A., LPC to the below entity.

Client Name:

Date of Birth:

Information may be shared for the purpose of (please check):

treatment planning     assessment     psychosocial information

discharge planning     coordination of services

other: \_\_\_\_\_

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Name of organization / person

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Address

City

State

Zip

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Office phone

Fax phone

I understand that this consent to release information will only be released to the aforementioned person(s)

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Client / Guardian Signature

Date

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Counselor Signature

Date