Victor B. Herring, MSW, LCSW, LLC

Board Certified Diplomate
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AUTHORIZATION FOR RELEASE OF INFORMATION

_____ Date of Birth_____
Name of Client (Print)

I hereby authorize _____
Name, Agency
_____
Address
_____
City, State, Zip
_____
Phone
to release social, psychological, medical, educational, or other information
(Specify) _____

to _____
Name
_____
Address
_____
City, State, Zip
_____
Phone
By placing the client's or parent/guardian's initials in the following blank _____, the two parties named above are authorized to exchange information.

By signing this document, the client or his/her parent(s)/guardian(s) release the above identified individuals/agencies from all liability with regard to the sharing of confidential information. This release will remain in effect until _____ or as long as the client continues in therapy with Victor B. Herring, MSW, LCSW, LLC.

_____ _____
Client's Signature Date

_____ _____
Parent Signature Date

_____ _____
Parent Signature Date