



SHARON COUNSELING CENTER

Sharon M. Walsh 37 Miller Drive Boonton Township, NJ 07005 (973) 402-2315

CONSENT FORM

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I, _____
(Name of client or participant)

Authorize Sharon M. Walsh, LCSW to release to

(Person or organization to which disclosure is to be made)

the following information: _____

The purpose for such disclosure is: _____

I understand that my records are protected under the Federal Confidentiality Regulation and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time.

This release shall be in effect for one year unless renewed or revoked in writing by _____
(Name of client or participant)

Dated this _____ day of _____, 20____.

X _____
(Signature of client)

X _____
(Signature of parent, guardian)

