

**Sherry E. Showalter, Ph.D., LCSW, BCD, M.Msc.**

Consent for Exchange of Confidential Information

I, \_\_\_\_\_, hereby authorize Dr. Sherry E. Showalter, to exchange information in a confidential and professional manner, to the organizations(s) or person(s) listed below:

_____ Name	_____ Institution
_____ Address	_____ Phone
_____ Name	_____ Institution
_____ Address	_____ Phone

This disclosure is to be made for the purpose(s) of:

- \_\_\_ Coordination of clinical treatment
- \_\_\_ Conducting counseling sessions
- \_\_\_ Furnishing information to my health care provider
- \_\_\_ Facilitating referral to treatment agency/institution
- \_\_\_ cooperating with present or prospective employer
- \_\_\_ Other: \_\_\_\_\_

This consent will remain valid, although it is subject to my revocation in writing at any time, except to the extent that any information has been released prior to revocation. Unless revoked by me sooner, this consent will expire on: \_\_\_\_\_  
Date

In consideration of this consent, I hereby release the above parties from any legal liability resulting from the release of this information.

Client Signature: _____	Date: _____
_____	Date: _____
Witness Signature: _____	Date: _____