Cheryl Warner, Ph.D.
Licensed Counseling Psychologist

Authorization to Release Information

I, _____, authorize **CHERYL B. WARNER, PHD** to: ___ (send) ___ (receive) the following information ____ (to) ___ (from) the following agencies or people:

_____

Name Address City State Zip_Phone

_____

Name Address City State Zip_Phone

_____

Name Address City State Zip_Phone

( ) Entire Record
( ) Behavior Programs
( ) Case Notes
( ) Intelligence Testing Results
( ) Personality Profiles
( ) Progress Reports
( ) Psychological Reports
( ) Psychological Testing Results
( ) Service Plans
( ) Summary Reports
( ) Medical Reports
( ) Other (specify) _____
_____
_____

The above information will be used for the following purposes:

( ) Planning Appropriate Treatment or Program
( ) Continuing Appropriate Treatment or Program
( ) Determining Eligibility for Benefits or Program
( ) Case Review
( ) Updating Files
( ) Other (specify) _____

I understand that I may revoke this consent at any time by providing written notice, and after one year from the below data, this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information.

Signature of Client _____ Date_____

Signature of Parent/Guardian _____ Date_____

Signature of Witness _____ Date_____
(if client is unable to sign)

Signature of Person Informing _____ Date_____
Client of Rights

Mail to: *Cheryl B. Warner, Ph.D.,, P.O. Box 112 Seneca, South Carolina 29679-0112*
864.650.0027 (Practice) *warner_phd@hotmail.com (Email)* *864.654.8027 (fax)*