JENNIFER THERIAULT, MSW, LCSW

AUTHORIZATION TO RELEASE INFORMATION

I__________________________________, give permission for **Jennifer Theriault, MSW, LCSW** to share and exchange information with ____________________________ for the purpose of coordinating services and treatment. This may include but is not limited to sharing information about a disability, psychiatric diagnosis, school, or other medical records.

Please list any information that you would not like shared:

No information will be shared with anyone not listed on this release.

The only time information may be shared without permission is when there is:

- Evidence of abuse or neglect
- The patient is presenting a danger to themselves or others
- A court order requires disclosing the information

This consent is valid until such time that treatment has terminated and I may revoke this consent at any time.

I confirm that **Jennifer Theriault, MSW, LCSW** has explained the purpose of this form to me and I understand its content. My signature below indicates my consent.

Signature:____
(parent signature if patient is a minor)

Date:____