VALERIE L. SCHWIEBERT, PH.D.
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AUTHORIZATION FOR RELEASE OF INFORMATION OR DOCUMENTS

Patient Name: _____

Date of Birth: _____/_____/_____ Social Security #: _____-_____-_____

I hereby authorize direct and/or written communication, regarding the above named patient, between Valerie L. Schwiebert, Ph.D. and the individual (s) listed below:

_____
(Agency name and/ or individual to be contacted)

Phone: (_____) _____ Fax: (_____) _____

Address: _____

City: _____ State: _____ Zip Code: _____

By signing this release of information, I understand that I authorize Valerie L. Schwiebert, Ph.D. to release and/or receive any medical or psychological records to/from the individual(s) or company listed above. I release Valerie L. Schwiebert, Ph.D. and Wake Counseling & Consulting PLLC personnel from any legal liability resulting from the release of information, with the understanding that Valerie L. Schwiebert, Ph.D. and Wake Counseling & Consulting PLLC personnel with adhere to professional safeguards. I understand that I have the right to receive a copy of this authorization upon request. I understand that I can revoke this consent at any time as long as I withdraw consent before initial contact between the parties has been made.

Patient/Guardian [Print]

Patient/Guardian [Sign] Date

Witness Date