Jenny Shealy, LCSW
67 Charlotte Street
Asheville, NC 28801
828-279-5369

RELEASE OF INFORMATION

I, _____, authorize a mutual release and exchange of

confidential information between Jenny Shealy, LCSW and

_____

Limitations on release:_____

The purpose of this release of information is to facilitate comprehensive care.

I understand this document, and that there are statutes and regulations protecting the confidentiality of this information. I understand that I may give or withhold my consent as I choose. I understand that this consent is voluntary, and that therapy is no way conditional upon giving this authorization. I understand that I may revoke this consent at any time except to the extent that the action based on this consent has already been taken.

Consent will expire no later than one year from today.

Client's signature: _____

Therapist's signature:_____

Date: _____