uFringo Counseling LLC

CONSENT TO EXCHANGE OF INFORMATION

I _____(Client or Parent/Guardian if client is under 18) authorize Liz Schnelzer, LCSW to exchange confidential information about:

_____
(Client Name)

with: _____
(Provider Name)

_____
(Provider Phone)

_____
(Provider Fax)

This information will be used for the purpose of coordinating mental health treatment and/or educational services. I understand that I can revoke this authorization at any time by providing my written intention to do so.

_____ _____

Signature of Client or Parent/Guardian if client is under 18 Date