

**In-Joy Therapy and Yoga
Consent for Release of Information**

I authorize my therapist, Sharon Hyman, to exchange information with the following individual(s):

Please provide name(s), phone number(s), fax number(s), and email address(es):

I recognize that this form of collaboration is very helpful to my treatment in therapy. This contract expires automatically with the termination of treatment. I recognize that there a charge for this kind of collaboration in increments of 30 minutes of the therapist's time.

Signature(s) of client(s) or parent/guardian if patient is minor

Date

Signature of witness/therapist

Date

Return the completed and signed form to:

Sharon Hyman, LCSW-C, RYT
In-Joy Therapy and Yoga
5808 Midhill Street
Bethesda, MD 20817
sharonhyman1@gmail.com
(301) 320-2022