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
sharonhyman1@gmail.com