CLIENT INFORMATION:

Today's Date: _____

Name: _____ **DOB**: ___/___/___

First *M.I.* *Last* **Age**: _____

Parent(s)/ Guardian(s) Name (if under 18 yrs.) _____

Address: _____ **Home or Work Ph #**_____

_____ **Cell Ph #:** _____

Email: _____ **OK to Text?** Yes No

Occupation/Employer and/or Grade/School _____

(If applies) **Marital Status**: single married divorced **How many children**? _____ **Ages?** _____

_____

	Name	*Phone / Fax*	*Email*
Physician		Pho: Fax:	
Therapist		Pho: Fax:	
Other		Pho: Fax:	

CONSENT TO OBTAIN & RELEASE INFORMATION:

I hereby authorize Sheri Barke, MPH, RD, CSSD to release my treatment records and to discuss my case with the health professionals listed above.

I understand that my records and treatment are confidential and cannot be released without my express written consent, unless legally obliged.

I am also aware of my right to revoke, in writing, this consent at any time, excepting any disclosure that has already occurred.

Client's Signature: _____ **Date**: _____

Parent / Guardian's
Signature (if under 18 yrs.): _____ **Date**: _____