

**Brighton Therapy Group**  
**Ruth Friga, LCSW-R, ACSW Psychotherapy, P.C.**  
**JoAnn McDermott, LCSW-R, ACSW Psychotherapy, P.C.**  
**M & D Schwab, LCSW-R, ACSW Psychotherapy, P.C.**  
**2000 Winton Road South, Building 4, Suite 100**  
**Rochester, New York 14618**

**Consent For Release of Information**

**Consent**

I hereby give permission for M & D Schwab, LCSW-R, ACSW Psychotherapy, P.C. , to  release  receives information about me. The contents of this consent have been discussed with me and my questions have been answered to my satisfaction. I understand that I have the right to withdraw my consent at any time except to the extent that requested information has already been provided. I understand that any information M & D Schwab, LCSW-R, ACSW Psychotherapy, P.C. receives from another agency/provider cannot be further released to another party. This exchange of information may occur with:

Agency/Primary Care Physician: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Expiration**

THIS CONSENT WILL EXPIRE *(please check/note below)*

Six months from signing  One year from signing

**Withdrawal**

I hereby withdraw this consent effective: \_\_\_\_\_

Client/Guardian Signature: \_\_\_\_\_

**Exceptions to Signed Consent Required by Regulatory Authority**

Medical/Psychiatric Emergency

Adult/Child Protective

Risk of Harm to Self/Others

Properly Executed Court Order

*\*All events of exception to consent need to be documented in the progress notes*

**Information Requested or to be Released**

The following information is being requested  
Or will be released unless noted below with  
checkmark (✓)

Intake/Screening Assess

Discharge Summary

Psychological Evaluation

Psychiatric Evaluation

Treatment Plan

Medication Record

Medical Hx/Lab Reports

Other: \_\_\_\_\_

**Purpose of Information released or requested is for  
Assessment and/or Treatment Planning, unless  
otherwise stated.**

Other: \_\_\_\_\_

**Signature**

Client's Name:(please print) \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Client/Guardian Signature: \_\_\_\_\_

Witness Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Return to the attention of: **DAVID SCHWAB, LCSW-R** \_\_\_\_\_

\_\_\_\_\_

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