

Jordan Shafer, MS, LPC

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**Consent To Release Or Obtain
Psychological/Psychiatric Information**

I, _____, hereby authorize Jordan Shafer, MS, LPC, to disclose information obtained in the course of my psychological counseling with him to _____. The disclosure of information is authorized herein as required for the purpose of providing me with full and complete mental health services.

I further authorize _____ to disclose pertinent treatment information to Jordan Shafer, MS, LPC. The disclosure of information is authorized herein as required for the purpose of providing me with full and complete mental health services.

This consent is subject to revocation by the undersigned at any time except to the extent that action has been taken in reliance thereon, and if not earlier revoked, it shall terminate on (projected end of treatment with Mr. Shafer):

(date, event, condition)

Client Signature

Date