Harriette Shiland McDonough, LMSW

Three Arms, LMSW, PLLC.

520 Franklin Avenue Suite L22

Garden City, NY 11530

516-680-2463/ harriettemcd@gmail.com

Consent to Release/Receive Information

Client _____

Date of Birth_____

I _____, hereby grant Harriette Shiland McDonough, LMSW to

Release or receive and/or receive information from the following persons:

Name_____
Phone_____

Name_____
Phone_____

Name_____
Phone_____

I understand that the release of information is for the purposes of enhancing the efficacy of my treatment.

Signature of
Client_____

Print Name_____

Signature of
Parent/Guardian_____

Date_____

Revised 6/3/15