Sky Snogren
MA, LPC

Release of Information Consent

I, ________________________________, GIVE SKY SNOGREN, MA, LPC PERMISSION

TO RELEASE INFORMATION TO ____

AS NECESSARY FOR MY TREATMENT.

Provider's Phone Number: _____________________________

☐ Check here if you would like this form to also give above-stated providers the ability to share information with Sky (TWO-WAY RELEASE OF INFORMATION).

This release will be in effect from _________________ to ___________________

____________________________________ ______________________

Client's Signature Date

____________________________________ ______________________

Therapist's Signature (Sky Snogren) Date