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Los Angeles, CA 90025

Confidential Client Information

Date_____

Name_____ Birth Date_____

Street Address_____

City_____

Home Phone_____ Cell_____

Email_____

Work Phone_____

Employer_____

Work Address_____
_____

Physician Name_____ Phone _____

Psychiatrist Name_____ Phone_____

Current Medications_____ Dose_____

In Case of Emergency Notify_____

Phone_____ Relationship_____

I authorize Sharon Schwartz, Ph.D to release or exchange pertinent clinical information regarding myself to/with_____
_____

Signature_____ Date_____

Signature_____ Date_____

Guardian Signature (if minor)_____ Date_____