

SHARON R. SCHWARTZ, PH.D.

Licensed Psychologist

PSY 12157

13400 Riverside Drive Suite 318

Sherman Oaks, CA 91436

6330 San Vicente Blvd. Suite 510

Los Angeles CA. 90046

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 _____