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Consent for Release of Confidential Information

Please fill this form and include any family members, previous therapists, your primary care physician and/or anyone else you would like me to speak with about your case. If this does not apply to you, you may leave this form blank.

Date:_____

Client Name(s): _____

Address: _____Address: _____

Phone number:_____

I, _____, ( ) client, ( ) parent, ( ) guardian, hereby authorize _ Anura Mathis, LPCC, _ to release or exchange information concerning my psychological or medical history/treatment.

Authorization is granted to:

_____ _____
Person/Agency Phone/Fax Number(s)

_____ _____ _____
Address City State Zip

I authorize the release of the following information:

- **__ Psychological or psychiatric evaluation**
- **__ Psychodiagnostic assessment results (testing)**
- **__ Treatment plan/summary**
- **__ Social History**
- **__ Medical history and information**
- **__As needed for treatment**
- **__For scheduling only**
- **__For Financial Purposes Only**
- **__ Other (specify) _____**

I understand that I may withdraw this authorization in writing at any time.

_____
Signature of Client/Parent/Guardian Please Print Name

Date:_____

***A copy of this release shall be as valid as the original.**