

Harding & Associates, Psychotherapy & Evaluation, PLLC

1521 Green Oak Place Ste 191
Kingwood, TX 77339
(346) 202-5619
Fax: 281-657-9697

Release of Information To and From Other Individuals/Agencies

Client: _____

Date of Birth: _____

I HEREBY AUTHORIZE:

Individual/Professional who will be communicating with Harding & Associates, Psychotherapy & Evaluation, PLLC

Name: _____

Address: _____

Phone: _____

Fax: _____

To release information TO and receive information FROM (This allows 2-way communication.):

Harding & Associates, Psychotherapy & Evaluation, PLLC (See above address/phone/fax information.)

I UNDERSTAND THAT SUCH DISCLOSURES WILL BE MADE FOR THE FOLLOWING PURPOSES:

Place an "X" next to the description(s) that apply.

- To assist in additional funding
- To assist in evaluation &/or treatment
- To provide information to person(s)
- To Coordinate Discharge placement/planning
- To assist in educational decisions
- Other: _____

AND WILL BE LIMITED TO THE FOLLOWING SPECIFIC TYPES OF INFORMATION:

Place an "X" next to the description(s) that apply.

- NO LIMITATIONS
- Medical/Psychological Records
- Psychological Reports
- Laboratory
- Discharge Summary
- Psychiatric Evaluation
- History/Physical
- Psychosocial History
- Educational/Vocational Assessment
- Other Confidential Information

Specify: _____

If I am signing as a parent of a minor child or guardian of a minor child, I further understand the records released may contain references to me or family.

This consent is subject to revocation by the undersigned at any time except that action has to be taken in reliance hereon, and, if not earlier revoked, this consent shall terminate within one (1) year of the date signed or on: _____

Client Signature

Client Printed Name

Parent/ Legal Guardian/Representative Signature

Date

Therapist Initial _____