

Parenting Guidance Services, LLC

Kevin R. Byrd, Ph.D., HSPP

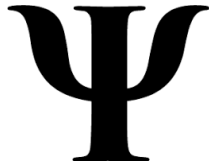
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CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

I, the undersigned, authorize and request Dr. Kevin Byrd of Parenting Guidance Services, LLC to release and/or obtain the following specific information pertaining to the treatment of _____ (Date of Birth: _____)

to/from:

Person/Organization: _____
Street Address: _____
City/State/ZIP: _____
Telephone: _____ Email: _____

I authorize Carmel Psychology to (check all that apply):
X Exchange with Release to Obtain from the party listed above

I authorize Carmel Psychology to exchange/release/obtain information:
 Verbally only Written form only X Both verbally and in writing

Description of health information to be exchanged/released/obtained (initial all that apply):
 X Psychological Evaluation
 X All Progress Notes/Appointment Records
 X Treatment Summary
 Medical History
 School Records
 X Drug/Alcohol Records
 Other: _____

The specific purpose of this disclosure:
 Coordinate Care/Treatment Planning
 Transfer Care
 Academic Planning
X Legal Proceedings
 Other: _____

I understand that this release will expire in 180 days, unless revoked by me which I have the right to do at any time. I understand that any revocation will not apply to any information that has already been released in reliance to this authorization and to information created expressly for disclosure to the person/entity listed above. I understand that any questions I have about the use or disclosure of this information can be directed to Parenting Guidance Services at any time.

Signature: _____
Printed Name: _____
Date: _____ Relationship to Patient: _____