Lisa Barber M.ED. Licensed Professional Counselor

Authorization to Release/Exchange Confidential Information

Patient Name:_____ D.O.B._____

I hereby authorize: *Lisa Barber M.ED., Licensed Professional Counselor, Registered Play Therapist*
Address: 5209 Heritage Ave. Ste. 210, Colleyville TX 76034 Phone: 817-545-7100x5 Fax: 817-545-4555

To release to/ To obtain from:
Name:_____
Address:_____
Phone:_____ Fax:_____

Information to be released (check all that apply):

___ Assessment/Social History ___ Treatment Plan/Summary ___ Lab Results
___Medication Information ___Verbal Communication
___Discharge Information ___ Psychiatric/Psychological Testing
___Other: _____

The purpose for this release is for the coordination of treatment.

I, the undersigned, understand that I may revoke this consent at any time by giving written notice to Lisa Barber. However, I also understand that any information released prior to my revoking this authorization shall not be a breach of my right to confidentiality.

If not earlier revoked, this consent shall expire on _____ or not exceed one year from the date of the patient signature.

To the party receiving this information: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42) CFR Part 2 prohibit you from making any further disclosure of it without the specific written consent of the person whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.
FOR PATIENT RECORDS APPLICABLE UNDER FEDERAL LAW 42 CFR PART 2

_____

Signature of Patient Date

_____

Signature of Parent/Legal Guardian or Representative Date

_____

Relationship to Patient

_____

Signature of Therapist/Witness Date