**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: _____
Email: _____

I authorize Dr. Byrd to (check all that apply):
X Exchange with ☐ Release to ☐ Obtain from the party listed above

I authorize Dr. Byrd 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 Xs please):
_____ X Psychological Evaluation
_____ X All Progress Notes/Appointment Records
_____ X Treatment Summary
_____ X 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. 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: _____