Lisa K. Phillips Ph. D.
LICENSED CLINICAL PSYCHOLOGIST
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AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

I _____ authorize Dr. Lisa Phillips to:

_____ release to:
_____ obtain from:
_____ exchange with:

_____ (Name of Person)
_____ (Address)
_____
_____ (Phone Number/Fax)

the following information pertaining to myself____ or my child____:

_____ treatment summary
_____ history/intake
_____ diagnosis
_____ psychological test results
_____ psychiatric evaluation/medication history
_____ dates of treatment attendance
_____ other (specify) _____

for the purpose of:

_____ evaluation/assessment and/or coordinating treatment efforts
_____ other (specify) _____

This consent will automatically expire one (1) year after the date of my signature as it appears below, or on the following earlier date, condition, or event _____
_____

I understand I have the right to refuse to sign this form, and that I may revoke my consent at any time (except to the extent that the information has already been released).

_____
Signature of Client/Parent/Guardian Date Date of Birth:_____

_____
Dr. Lisa Phillips, Ph.D. Date
Licensed Clinical Psychologist # PSY 25324