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AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, with my signature below, give authorization for Alan Barclay, MA, LMFTA, MHP to discuss information relevant to my case with the below-named person.

Name: _____

Address: _____

_____

Telephone: _____

Fax: _____

Information to be released is to be limited to:

____ Intake and history
____ Diagnosis and treatment plan
____ Psychological test results
____ Other (specify): _____

_____ Treatment progress
_____ Dates of attendance
_____ Discharge summary
_____ Billing and payment

for the purpose of:

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

This release shall be valid until the termination of treatment or until withdrawn in writing by the patient during the course of treatment. 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 information has already been released).

Patient Name: _____

Patient Signature: _____

Date: _____