AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

Patient Name: _____ **D.O.B.** _____

I hereby authorize:

Andrea Johnson LPC
5209 Heritage Ave Suite 210
Colleyville, TX 76034
469.305.2820

6401 El Dorado Pkwy Suite 306
McKinney, TX 75070
fax: 817.545.4555

To release/exchange from:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Information to be released (check all that apply):

☐ Assessment/Social History ☐ Treatment Plan/Summary ☐ Progress Notes ☐ Discharge Summary
☐ Medication Information ☐ Verbal Communication ☐ Lab Results ☐ Psychiatric/Psychological Testing
☐ Other: _____

The purpose for this release is: _____

I, the undersigned, understand that I may revoke this consent at any time by giving written notice to my clinician. 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 will expire one (1) year from the date of the patient signature as it appears below.

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 to 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 Representative (Guardian)/Relationship to Patient **Date**

_____ _____
Signature of Therapist **Date**