LSW
PSYCHOLOGICAL SERVICES
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RELEASE OF CONFIDENTIAL INFORMATION CONSENT FORM

I, _____
(Client, Parent, or Guardian/Legal Representative's Name)

authorize LSW Psychological Services, PLLC to release to and/or receive from

Name:_____

Phone:_____ Fax:_____

the following information (please initial):

_____Relevant mental health, medical, educational, or legal information

_____Billing & Scheduling Information

regarding: _____my child (child's name): _____.
_____myself.

Please list any information that you do **not** wish to disclose_____.

This information will be used to facilitate treatment and/or evaluation of myself or my child.

This consent to disclose information may be revoked by me, by written notification, at any time except to the extent that action has already been taken in reliance thereupon. I also understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and is no longer protected by HIPAA Privacy Rules.

This consent, unless expressly revoked earlier, expires upon (check one):

____ Treatment/Assessment has been completed (no longer than 3 months after last contact).
____ Date: _____
____ Condition: _____
____ Event: _____
(Please fill in an event that relates to the individual or the purpose of the use or disclosure)

_____ _____
Signature of Client, Parent, or Guardian/Legal Representative Date

If applicable, specify the relationship of the legal representative: _____