PSYCHOLOGY HOUSTON, PC
THE CENTER FOR COGNITIVE BEHAVIORAL TREATMENT

Release of Information

Date: ____________________________

Patient Name: ____

Name of Patient's Legal Guardian (if younger than 18): ___________________________________

I request and authorize my doctor/clinician at Psychology Houston, PC to provide both written and verbal confidential information regarding my history, diagnosis, and treatment plan on an ongoing basis to the following individual (parents, doctors/physician, therapist, school, psychiatrist, etc):

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The information to be disclosed includes:

- ☐ Complete Psychological Record
- ☐ Intake Assessment
- ☐ Progress Notes
- ☐ Psychological Assessment Results
- ☐ Clinical Summary
- ☐ Billing Records

Contact information for the individual you are authorizing Psychology Houston, PC to contact:

Phone: _________________________________

Email: _________________________________

Fax: __________________________________

Similarly, I hereby authorize Psychology Houston, PC to receive information from the second party on an ongoing basis. In signing this form, I fully realize that I waive my right to confidentiality by allowing full communication between Psychology Houston, PC and the second party about the patient. This release may be terminated by me at any time by providing Psychology Houston, PC with written and dated notification.

Signature:

____ ____________________________

Patient/Legal Guardian Date