

★ **The Center for Learning and Development** ★

P.O. Box 293504, Lewisville, TX 75029

Phone: 817-929-1900

RELEASE OF INFORMATION CONSENT FORM

PATIENT NAME: _____ DATE: _____

DOB: _____ SSN: _____

PLEASE BE ADVISED THAT: the information you authorize for release may include information regarding mental health and/or drug alcohol use/abuse.

I, _____, hereby authorize The Center for Learning and Development to (send / receive) information (to / from)

FACILITY: _____

Phone: (____) _____ Fax: (____) _____

On the above named patient, for the following purpose:

Insurance Payment My Therapist's use Other: _____

THE INFORMATION TO BE RELEASED IS:

- | | |
|---|--|
| <input type="checkbox"/> Academic Testing Results | <input type="checkbox"/> Psychological Testing Reports |
| <input type="checkbox"/> Progress Reports | <input type="checkbox"/> Discharge Plan |
| <input type="checkbox"/> Consultation | <input type="checkbox"/> Other: _____ |

This authorization covers release by:

- Mail Phone Fax Email

This authorization will remain in force from the date of my signature and may be revoked upon written notification. Withdrawal of consent does not affect any information disclosed prior to the written notice of withdrawal.

Confidentiality notice: This is strictly confidential material and is for the information of only the person to whom it is addressed. No responsibility can be accepted if it is made available to any other person, including the Subject of this correspondence. Any duplication, transmittal, re-disclosure or re-transfer is expressly prohibited. Such disclosure may be subject to civil or criminal liability.

WITNESS SIGNATURE

PATIENT SIGNATURE
(If patient is a minor, Parent or Guardian Signature)

DATE : _____