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CONSENT TO RELEASE MEDICAL RECORDS

Optional: For information from psychiatrist, therapist or medical doctor

CLIENT NAME: _____

Address: _____

City: _____

Home Phone: _____ **Work** _____ **Cell** _____

This consent authorizes Judith L. Sloan-Price, LCSW to:

___ **release information regarding the above named patient to:**

___ **receive information regarding the above named patient from:**

NAME: _____

Organization: _____

Address: _____

City: _____ **State:** _____ **Zip** _____

Phone: _____ **Fax:** _____

The information below will be disclosed/requested:

- | | |
|---|--|
| ___ Entire Record | ___ Initial Assessments & Final Diagnoses |
| ___ Psychotherapy Notes | ___ Information regarding drugs and alcohol |
| ___ Mental Health Notes | ___ Information regarding HIV/AIDS |
| ___ Hospital notes/discharge summaries | ___ Psychological testing results |
| ___ List of current/previous medications | ___ Vocational testing results |
| ___ History & Physical results | ___ Other: _____ |

The purpose of this disclosure/request is:

___ **Coordination of Care** _____ **Treatment Plan**

___ **Other** _____

This consent may be revoked at any time by providing written notice. By signing this form, the patient acknowledges that s/he has been given information about what is to be disclosed/requested, the purpose of this disclosure/request, and who will receive this information. Signing of this form by the patient also releases Judith Sloan-Price, LCSW from any legal liability resulting from the release of this information. Consent to this disclosure will expire in eighteen months from the date signed unless otherwise designated below.

Patient Signature **Date**