

Judith L. Sloan-Price, LCSW
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CONSENT TO RELEASE MEDICAL RECORDS

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 _____