Judith L. Sloan-Price, LCSW
6904 Fireoak Drive
Austin, TX. 78759
512-922-2256 512-336-9351 (fax)

Please complete if you are taking medication for a mental health issue e.g. anxiety, depression or if you want me to be able to communicate with another therapist, doctor or other person

CONSENT TO RELEASE MEDICAL RECORDS

CLIENT NAME: _____ DOB:_____
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