

# Release of Information Consent

Client's Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_  
Telephone: \_\_\_\_\_ DOB: \_\_\_\_\_

I, \_\_\_\_\_, authorize **Alice Locke Chezar, M.A., MFT, ATR** (Lic.#MFC 44964) to  
exchange information with:

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_

- |   |   |
|---|---|
| <input type="checkbox"/> Academic testing results     | <input type="checkbox"/> Psychological testing results        |
| <input type="checkbox"/> Behavior programs            | <input type="checkbox"/> Service plans                        |
| <input type="checkbox"/> Progress reports             | <input type="checkbox"/> Summary reports                      |
| <input type="checkbox"/> Intelligence testing results | <input type="checkbox"/> Vocational testing results           |
| <input type="checkbox"/> Medical reports              | <input type="checkbox"/> Entire record, except progress notes |
| <input type="checkbox"/> Personality profiles         | <input type="checkbox"/> *Psychotherapy Notes                 |
| <input type="checkbox"/> Psychological reports        | <input type="checkbox"/> Other, specify: _____                |

The above information will be used for the following purposes:

- Planning appropriate treatment or program
- Continuing appropriate treatment or program
- Determining eligibility for benefits or program
- Case review
- Updating files
- Other (specify) \_\_\_\_\_

I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after **1 year** this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization.

Your relationship to client:  Self  Parent/legal guardian  Personal representative  
 Other (describe) \_\_\_\_\_

If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

Client's Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Parent/guardian/personal representative (if applicable)  
Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Witness (if client is unable to sign)  
Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_