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CONSENT FOR THE RELEASE OF INFORMATION

Client Name: _____ DOB: _____

Social Security Number: _____

Parent/Guardian Name: _____

On behalf of myself son daughter, I _____
Authorize Todd S. Larsen, Ph.D., practicing at 7272 Wurzbach, Suite 1504, San Antonio, Texas

To provide information to: _____ To receive information from: _____
 To speak by telephone with: _____

(agency/department/name)

(phone number/ address)

The following information:

Intake/Social History Psychological Testing Report School Report
 Clinical / treatment summary Termination Summary Treatment Plan
 Other (describe): _____

For the purpose of: Insurance claim continued care by another provider Academic placement
 coordination of treatment legal issue (describe) _____
 other (describe): _____

I, the undersigned certify that I have the legal right to request release of information if this is for a minor for whom I am a parent or guardian. I understand that I may revoke this consent at any time except to the extent that action has already been taken in reliance on it. In any event, this consent will expire within ninety (90) days from when it was signed, unless another date or condition is indicated below:

release is effective until treatment is terminated.
 release is effective until the date indicated: _____.

To the party receiving this information: This information has been disclosed to you from records, whose confidentiality is protected by federal law. Federal regulations (42CRF part 2) prohibits you from making further disclosure of it without specific written consent for the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information in not sufficient for this purpose.

Signature of Client

Date

Signature of parent/guardian (if client is a minor)

Date