Only fill this out if you want Dr. Adams to talk with your previous therapist or counselor.

Kathleen Adams, Ph.D.
3355 Bee Caves Road, Suite 611
Austin TX 78746
(512) 327-8311

CONSENT FOR RELEASE OF CONFIDENTIAL PATIENT INFORMATION

This consent authorizes Dr. Kathleen Adams or her representative to release the following information on:

_____
Patient Name/Date of Birth

For the purpose of (Please initial):

____Insurance Claim
____Completing Clinical Assessments
____Treatment Planning & Coordination
____Legal Action
____Continuity of Care
____Treatment of Minor Child
____Referral

Other (Please state reason): _____

Recipient(s) _____

Information to be disclosed (Please initial):

____Discharge Summary
____Treatment Plan
____Handwritten Notes
____Entire Record
____Face Sheet
____Verbal Communications
____Other

Consent expires: 1. At the end of any treatment _____ Initial
2. _____ _____ Initial

I understand I may refuse to release my record. I understand that I may revoke this consent in writing at any time except to the extent that action has already been taken place. I understand that Dr. Adams has no control over my records once they are released to a third party. I understand I have a right to a duplicate of this form for my record.

_____
Patient Signature Date Signed

Legally Qualified Representative	Specify relationship to patient	Date Signed
Witness Signature	Title	Date Signed