Patient Authorization for Exchange/Release of Information for other Medical or Mental Health Providers involved in your care AND/or for family that you wish to have involved in your care.

Your Name:____

Address: ____

City: ___________________ **State:** _________ **Zip Code:** __________

Home Phone: ________________________**Cell:** __________________

I authorize Cindy Barrow, LCSW, to exchange and/or release clinical information with other providers of my care or to specific family members involved with my care. This information includes diagnosis, treatment goals, and treatment progress. Cindy Barrow may release progress notes and my initial diagnostic assessment.

Provider of Your Care / or Family Member:

Name: ____

Address: ____

Phone Number: ________________________**Fax:**_______________

I understand that I have the right to revoke this authorization at any time. My revocation becomes effective when delivered in writing or requested during a therapy session. This

authorization will automatically expire in one year from the date you place on this form.

I understand that there may be a fee of 25 cents per page for any copies of records that Cindy Barrow will make of my medical record that is requested by your other providers of your care or by you.

____

Client Signature   Printed Name

____

Date

____

Witness Cindy Barrow, LCSW