**Billy Grammer, L.P.C. / L.M.F.T. / C.S.T**

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# AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

RE:_____ Date of Birth: _____

This is to authorize _____

_____

_____

Address City State Zip

to disclose and release any information, including psychiatric and psychological records, of the above-captioned individual to _____, who is authorized to discuss all matters pertinent to the progress of the patient.

This information is considered instrumental to the ongoing evaluation and treatment of this patient.

Data particularly requested include:

| | |
|---|---|
| _____ Psychiatric Information | _____ Social Welfare Data |
| _____ Psychological Testing | _____ Rehabilitation Records |
| _____ Educational Records | _____ Legal Information |
| _____ Medical Information | _____ Psychotherapy Notes or Records |

***Date:*** _____
(Valid for one year from the above date)

***Signature:*** _____
Patient, Parent, Legal Guardian

_____
Relationship to Parent