

GEORGE P. GLASER, LCSW

3103 Bee Cave Rd • Suite 101 • Austin, Texas 78746
512-371-9418 (voice & fax) • george@georgeglaser.com

CONSENT TO RELEASE CONFIDENTIAL INFORMATION

I, _____, _____ hereby authorize
(Client's Name) *(DOB)*

to release the following types of confidential information about me /my child to
George P. Glaser, LCSW.

- | | | |
|---|----------------------------------|---|
| <input type="checkbox"/> Assessment/
Psychological Testing | <input type="checkbox"/> History | <input type="checkbox"/> Progress Notes |
| <input type="checkbox"/> Treatment Summary | <input type="checkbox"/> Lab | <input type="checkbox"/> X-ray |

Such information is necessary for assessment and continuity of care. I understand that I may revoke this consent at any time by informing the above parties in writing. This release is valid until _____.

I give my permission for the involved parties to communicate by e-mail: Yes No

In consideration of this consent, I hereby release the above parties from any legal liability for the release of this information.

Signature: _____ Date: _____
(Client)

Signature: _____ Date: _____
(Parent or Guardian)

Signature: _____ Date: _____
(Witness)