

Linda Brase, M.A, LPC
Licensed Professional Counselor

4131 Spicewood Springs Road, Suite K-6 Austin, Texas 78759 512.496.4848

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CONSENT FOR RELEASE OF CONFIDENTIAL PATIENT INFORMATION

This consent authorizes Linda Brase, M.A., LPC or her representative to release the below specified information about:

Name	Date of Birth	Social Security Number
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To:

Recipient's Name

Recipient's Contact Information

For the purpose of: (Please initial)

- | | |
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| <input type="checkbox"/> Insurance Claim | <input type="checkbox"/> Continuity of Care |
| <input type="checkbox"/> Completing Clinical Assessments | <input type="checkbox"/> Treatment of Minor Child |
| <input type="checkbox"/> Treatment Planning and Coordination | <input type="checkbox"/> Referral |
| <input type="checkbox"/> Legal Action | <input type="checkbox"/> Other (specify) _____ |

Information to be disclosed: (Please initial)

- | | |
|---|--|
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Treatment Plan |
| <input type="checkbox"/> Verbal Communication | <input type="checkbox"/> Other (specify) _____ |
| <input type="checkbox"/> Summary of Entire Record | |

Consent expires on: _____

I understand that 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 taken place. I understand that Linda Brase 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
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Legally Qualified Representative	Relationship to Patient	Date Signed
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Witness Signature	Date Signed
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