Consent For Treatment

Nahal Delpassand, PsyD, PLLC
Licensed Psychologist
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Austin, TX 78731
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RELEASE OF INFORMATION

Name of Client: _____

Date of Birth: _____

_____ (*initial*) I hereby give permission to **Nahal Delpassand, PsyD, PLLC** to release, orally or in writing, information concerning me to the person or agency named below.

_____ (*initial*) I hereby give permission to the person or agency named below to release, orally or in writing, information concerning me to **Nahal Delpassand, PsyD, PLLC.**

_____ (initial) I additionally hereby give permission for the disclosure to include information in my records about alcohol, drugs, and HIV status.

Individual or Agency with whom information is to be shared:

Name: _____ Phone: _____

Address: _____ Fax: _____

_____

This authorization is limited to the following types of information:

☐ Confirm status in therapy ☐ Relevant history
☐ Evaluation of progress ☐ Diagnosis
☐ Treatment plan ☐ Treatment summary
☐ All information ☐ Phone consultation
☐ Other: _____

This release of information is necessary for the purpose of:

☐ Continuity of care
☐ Coordination of treatment services
☐ Referral
☐ Other: _____

This request has been made voluntarily and without coercion. I understand that this authorization to release information will expire on _____, and that I may terminate it at any time, in writing, if I so desire.

_____ _____
Client Signature *Date*

_____ _____
Witness Signature *Date*