Consent For Treatment

Nahal Delpassand, PsyD, PLLC
Licensed Psychologist
1600 W. 38th St. Suite 428
Austin, TX 78731
EMAIL: Nahaldelpassand@hushmail.com

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: ______________________

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This authorization is limited to the following types of information:

- ☐ Confirm status in therapy
- ☐ Evaluation of progress
- ☐ Treatment plan
- ☐ All information
- ☐ Relevant history
- ☐ Diagnosis
- ☐ Treatment summary
- ☐ 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*