David Barton, MA, LPC
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REQUEST/AUTHORIZATION TO RELEASE CONFIDENTIAL RECORDS AND INFORMATION

I hereby authorize:
Person or facility: ____
Address: ____ Phone: ____________
____

to exchange information/records about ___________________________, born on ______________,

with:
Person or facility: ____
Address: ____ Phone: ____________
____

for the following purpose(s):
____ Further mental health evaluation, treatment, or care
____ Treatment planning
Other: ____

These records concern the time between _______________________ and ____________________.

The information to be disclosed is marked by an X on the lines below:
____ Medical history and evaluation(s)
____ Mental health evaluations
____ Developmental and/or social history
____ Educational records
____ Progress notes, and treatment or closing summary

Other: ____

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I have had explained to me and fully understand this request/authorization to release records and information, including the nature of the records, their contents, and the consequences and implications of their release. This request is voluntarily made on my part. I understand that I may take back this consent at any time, except to the extent that action based on this consent has already been taken. This consent will expire automatically after one year from the date on which it is signed, or upon fulfillment of the purposes stated above.

____
Signature of client

____
Printed name

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____
Date