AUTHORIZATION FOR EXCHANGE/RELEASE OF INFORMATION

PATIENT INFORMATION			
LAST NAME	FIRST NAME	MI	DATE OF BIRTH
STREET ADDRESS	CITY, STATE		ZIP CODE

I do hereby consent to the exchange and/or disclosure of information regarding the evaluation and treatment of the above named person and acknowledge that I have the legal right to grant this authorization for release of information.

By and between **Mind Works**, located at: 8207 Callaghan Rd., Suite 425, San Antonio, TX 78230.
AND

NAME/BUSINESS	PHONE NUMBER	FAX NUMBER
STREET ADDRESS	CITY, STATE	ZIP CODE

The disclosure of information and records authorized herein is done so to facilitate the continuity of care, and/or assistance with diagnosis, and treatment planning. I specifically request that the following information be released:

Psychological Evaluation/Testing Results

Progress Notes (Diagnostic Assessment & Treatment Plan)

Phone Calls/Emails

Other ____

Please specify any particular instructions or restrictions for release of information:

I understand that I may revoke this authorization at any time, except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically at the time specified below. This consent will expire: ________________

I agree that a photocopy/fax of this authorization is to be considered as effective as the original.

Signature of client/Parent/Legal Guardian   Relationship to Client

Witness   Date