Consent to Release Information

I___________________(patient or guardian) **authorize Dr. Audrey Burgess to release protected health information (PHI) for** ______________________(patient) **with the limits described below.**

Release information to (check all that apply):

- o Physician _________________________________
- o Psychiatrist _________________________________
- o School Personnel _________________________________
- o Employer _________________________________
- o Insurance _________________________________
- o Psychologist _________________________________
- o Therapist _________________________________
- o Other _________________________________

To expire on: __________

Description of information to be disclosed:

- o Full report
- o Mental Status
- o History
- o Cognitive/Achievement test results and interpretation
- o Personality testing results and interpretation
- o Treatment plan
- o Prognosis/Risk
- o Other____

I understand that I may revoke this authorization at any time by notifying Dr. Burgess' office.

____

Patient or Guardian Signature   Date

____

Patient or Guardian Printed Name