

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):

- Physician _____
- Psychiatrist _____
- School Personnel _____
- Employer _____
- Insurance _____
- Psychologist _____
- Therapist _____
- Other _____

To expire on: _____

Description of information to be disclosed:

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