Laurie Donovan
Licensed Marriage and Family Therapist
Licensed Clinical Social Worker
(512)731-7141 fax (512-444-6124

1823 Fortview Ste. 106
Austin, Tx 78704
ldonovan @austin.rr.com

Release of Private Health Information

Client name_____ Date of Birth_____

Address_____

I give my permission for __Laurie Donovan, LMFT, LCSW_____
(Name, address, telephone number)

to release and receive from _____
(name address, telephone number)

the following information regarding the client/family:
____Initial Assessment
____Information on Progress in Therapy
____Treatment Plan
____ Medical Information
____ Behavior and progress in school
____ Termination Summary
____ Other

for the purpose of:
____Coordination of Services
____To Assist in Evaluation
____To Provide Continuity of Treatment
____Payment of Fees
____Other

I understand that I can revoke this authorization at any time, except to the extent that action has been taken. If not earlier expressly revoked, it shall expire one year from the date signed, or when the treatment episode has ended if longer than one year..

I understand that the specific type of information to be disclosed may include a history of DRUG or ALCOHOL ABUSE or MENTAL HEALTH TREATMENT.

_____ _____
Client Signature Date

_____ _____
Parent/Legal Guardian (if minor) Date

_____ _____
Witness Date