

Patient Authorization for Exchange/Release of Information for other Medical or Mental Health Providers involved in your care AND/or for family that you wish to have involved in your care.

Your Name: _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone: _____ **Cell:** _____

I authorize Cindy Barrow, LCSW, to exchange and/or release clinical information with other providers of my care or to specific family members involved with my care. This information includes diagnosis, treatment goals, and treatment progress. Cindy Barrow may release progress notes and my initial diagnostic assessment.

Provider of Your Care / or Family Member:

Name: _____

Address: _____

Phone Number: _____ **Fax:** _____

I understand that I have the right to revoke this authorization at any time. My revocation becomes effective when delivered in writing or requested during a therapy session. This

authorization will automatically expire in one year from the date you place on this form.

I understand that there may be a fee of 25 cents per page for any copies of records that Cindy Barrow will make of my medical record that is requested by your other providers of your care or by you.

Client Signature

Printed Name

Date

Witness Cindy Barrow, LCSW

After completing form, please click the SUBMIT Button. This will open a new email using your default email application. If you do not have one installed on your device, just save the form and email it to clbarrow66(AT)gmail.com. *Please be sure to input the email correctly as you are emailing Private & Confidential information.*