LAUREN JORDAN, LCSW, CST
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Suite 818
Dallas, TX 75243
214-692-6100

CONSENT FORM FOR RELEASE OF CONFIDENTIAL INFORMATION

_____

Client Name_____

Address _____

The release or exchange of information shall be to the individual or agency listed below:

TO: _____FROM: _____

_____ _____

_____ _____

_____ _____

I authorize Lauren Jordan, LCSW, CST as my therapist, to release and/or receive the following confidential information as deemed pertinent to my therapy. I understand that I can revoke my consent at any time by written notice.

Phone consultation with physician _____

Phone consultation with attorney _____

Release copies of my records _____

Release dates of attendance _____

Release diagnosis _____

Brief letter to physician regarding therapy _____

Other _____

This authorization for the exchange of information is made with informed consent. A photographic copy of this authorization will be considered as effective as the original.

Signature of client _____

Date _____