Jim Colbert, M.Ed., LPC

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Georgetown, Texas 78628

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Physical: 1504 Leander Rd
Georgetown, Texas 78628

Release of Information

Client Name:_____ DOB ____/____/____ Date: _____/_____/_____

I, _____ , (client, or parent / guardian) authorize the **reciprocal** release of confidential information of_____(Adult client's name or name or minor child or adolescent) to/from Jim Colbert, M.Ed., LPC. By my signature here, I allow the identified agency / person to release confidential information to be used in the formulation of a comprehensive assessment and provision of services. I realize this information will be held in confidence and is privileged communication between the two agencies only, and will not be released further to any other person or agency without an additional authorization from this client.

Agency / Person Requested to Release Information: Information should be released:

_____

___ Verbally ___Written _____ Photocopied / digital transcript _____ fax / email _____Any

Information to be released. Mark items to be disclosed:

____Entire record as needed ____Consult only ____Social History ___Psychological Testing

____ Mental Health history ____ Evaluation / Summary ____Treatment Plan ____School Record

____Medical Record ____Education or School Testing ____Discharge Summary

____Medication Information / History or Log

Information to be released for the purpose of:

___ Consultation and development of comprehensive treatment plan ____Continuity of Care

____Enable Employer to make a Determination ____Bariatric Determination ____Other

_____ _____

Parent or Guardian Date Jim Colbert, M.Ed., LPC Date

This authorization can be revoked at any time by written request and will expire one year from the above signed date.