Karla Austin, Ph.D.
Licensed Psychologist
1425 W. Pioneer Suite 267
Irving, Texas 75061

Office: 972-986-0150
Fax: 972-313-2281

Consent to Release Confidential Information

Client Information. Please Print Clearly
Name: _____
Address: _____
_____
Phone Number: _____
Date of Birth: ____/____/____

☐ I want Karla Austin, Ph.D. to release information to:

Name_____
Address_____
_____

Phone Number:_____
Fax Number: _____
Email:_____

☐ Please release my confidential records to:
Karla Austin, Ph.D.
1425 West Pioneer Drive
Irving, TX 75061

Office: 972-986-0150
Fax: 972- 313-2287
Email: Karla@KarlaAustin.com

By signing this form, I am authorizing Karla Austin, PhD to release otherwise confidential psychological information to the person or organization I designate. I understand that released information will be for professional use only to help in diagnosis or treatment. I furthermore release all parties here within from any legal liability resulting from the release of this information, with the understanding that all parties involved will exercise safeguards while using this information. This request is entirely voluntary on my part. I understand I may cancel or modify this Consent to Release Confidential Information within 90 days, except to the extent that action based on this consent has already been taken.

The purpose for this information is to: _____
_____
_____
_____
_____
_____
_____
_____
_____
_____

I understand that I do not have to agree to release confidential information and that I my withdraw this consent at any time. A facsimile of this form will be regarded as valid as the original.

Signature _____ Date: _____