CHADWICK ROYAL, PHD, LCMHCS

LICENSED CLINICAL MENTAL HEALTH COUNSELOR SUPERVISOR

AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

This form cannot be used for the re-release of confidential information provided to Chadwick Royal, PhD, LCMHCS by other individuals or agencies. Such requests should be referred to the original individual or agency.

I _____ authorize Chadwick Royal, Ph.D., LCMHCS to:

_____ release to: _____
_____ obtain from: _____
_____ exchange with: _____

the following information pertaining to myself:

_____ treatment summary
_____ history/intake
_____ diagnosis
_____ psychological test results
_____ psychiatric evaluation/medication history _____ dates of treatment attendance
_____ therapy notes
_____ other (specify) _____

for the purpose of:

_____ evaluation/assessment and/or coordinating treatment efforts
_____ other (specify) _____

This consent will automatically expire one (1) year after the date of my signature as it appears below, or on the following earlier date, condition, or event _____
_____.

I understand I have the right to refuse to sign this form, and that I may revoke my consent at any time.

_____ Date of Birth:_____
Printed Name of Client/ Date

_____
Signature of Client / Date

_____
Signature of Witness / Date

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