1612 Williams Dr.
Georgetown, TX 78628
(512) 521-4652

AUTHORIZATION FOR RELEASE/EXCHANGE OF RECORDS OR INFORMATION

I understand that my records are protected under federal and state regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulation. I also understand that I may revoke this authorization by writing the word "REVOKE" along with my signature and the date at any time after it is signed, except to the extent that action has been taken in reliance on it. I also understand that permission to release family records must come from all members of the family age 18 or over participating in the services, or information released must be restricted only to information regarding the person(s) who signs the release on behalf of him/herself or a minor child of whom they have legal rights to consent for treatment. If not previously revoked, this authorization will automatically expire one year following completion of the services with this provider.

I authorize Amy Eichler, Ph.D., LP, LSSP, Suzanne Hatchett, Ph.D., or Barbara Corff, Ph.D. to:
( ) Disclose information to: AND/OR ( ) to obtain information from:

( ) _____
Name phone
( ) _Therapists associated with Turning Point Psychological and Counseling Services, PLLC_____
Name phone

( ) My attorney: _____
Name phone

( ) Other party's attorney: _____
Name phone

Information to be disclosed/exchanged include:
( ) Any relevant information in my record
( ) Only the following information (client must initial each item)
___ information regarding attendance at scheduled appointments
___ clinical records
___ oral consultation only regarding progress
___ Other: _____

_____
Client name (print) Signature date

_____
If client is under 17, parent name (print) Signature date