Richard H. Barrett, II, Ph.D.
Clinical Psychologist
5601 Duncan Rd **Ph: (479) 561-3144 Fx: (866) 988-3317** **211 North 34th St.**
Fort Smith, AR 72903 **Rogers, AR 72756**

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Name of Patient:____ Date of Birth:___________________________________

I hereby authorize the release of the following specific information:
(check all items)

Yes	No	
___	___	(1) Medical history, examination and treatment reports.
___	___	(2) Psychological test reports (including psychoeducational)
___	___	(3) Psychiatric evaluation reports.
___	___	(4) Social history data including family, education, employment, etc.
___	___	(5) Summary of previous mental health treatment.
___	___	(6) Periodic reports of current treatment progress including attendance and participation.
___	___	(7) Notification of referral source of initiation and termination.
___	___	(8) Permission for Dr. Barrett to use information received in reports prepared for ________________.
___	___	(9) Other (specify):____ ______________________.

From/To Dr. Richard Barrett

From/To____
(Name of agency or individual)

____
Address City State/Zip

I understand that this information will be used for the following specific purposes: (Check all items)

Yes	No	
___	___	(1) To develop a diagnosis, treatment and rehabilitation plan.
___	___	(2) To Coordinate medical, psychological and social rehabilitation processes.
___	___	(3) To comply with court order.
___	___	(4) Specify:____.

I, the undersigned, understand that I may revoke this consent at any time in writing, except to the extent that action has been taken in reliance on it and that in any event this consent shall expire upon the end of treatment or in one year, whichever is later. I understand any of the above requested information may include results of alcohol/drug (substance) abuse testing and/or diagnosis and treatment of psychological disorders. I agree that a copy of this form with my signature shall be considered as valid as the original.

TO THE PARTY RECEIVING THIS INFORMATION: This information is being disclosed to you from records where confidentiality may be protected by federal and/or state laws. If so, regulations 42 CFR, Part 2, prohibit further disclosure without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations.

_______________________________________ _______________________________________
Patient's Signature Parent or Guardian

_______________________________________ _______________________________________
Date Witness (state relationship to patient)