

**Karla Austin, Ph.D.**  
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**CONSENT FOR RELEASE AND EXCHANGE OF INFORMATION**

Karla Austin, Ph.D. is authorized to release and exchange confidential information regarding:

Print Client's Name: \_\_\_\_\_

With:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City                      State                      Zip Code

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Information to be released and/or exchanged:**

- Treatment information including, but not limited to, diagnosis, services provided, number of sessions, progress, medications with dosages, and reports.
- Psychological evaluation(s), psychiatric report(s), progress report(s).
- School records including report card, ARD paperwork, placements, etc.
- Employer for employment evaluations/reports, etc.
- Physician's diagnosis, treatment, prognosis, etc.
- School diagnostician's and /or psychological report(s).

Other (specify) \_\_\_\_\_

I understand that I may revoke this authorization at anytime. Without my expressed revocation, this authorization will automatically expire:

- Upon receipt of information requested
- Upon one year after date of signature

I further acknowledge that the information being released/exchanged was fully explained to me.

\_\_\_\_\_  
Signature of Responsible Party

\_\_\_\_\_  
Date