SOUTHLAKE PSYCHIATRIC & COUNSELING CENTER
542 SILICON DR, STE. #100
SOUTHLAKE, TEXAS 76092
(817) 329-3300 OFFICE (817) 329-3312 FAX
WWW.SOUTHLAKEPSYCH.ORG

# CONSENT FOR RELEASE OF MEDICAL INFORMATION OF A MINOR CHILD

I, _____ for _____ d.o.b. _____
Parent/Guardian's Name Patient's Name

_____
Address

_____
City State Zip

DO HEREBY AUTHORIZE **WILLIAM T. GOLDMAN, MD** OR HIS DESIGNATED AGENT

TO **RELEASE INFORMATION TO** or **RECEIVE INFORMATION FROM** THE FOLLOWING PARTIES:

_____

_____

_____

CONCERNING:

- ☐ Psychiatric Evaluation
- ☐ Psychological Evaluation
- ☐ Summary of Services
- ☐ Attendance & Progress
- ☐ Disability Assessment Information
- ☐ Medical Information (Specify) _____
- ☐ Other (Specify) _____

The disclosure of verbal and/or written information authorized here is made for the following purpose(s):

_____

_____
Patient/Parent/Legal Representative Date

_____
Relationship of Legal Representative Date

_____
Witness Date

## WITHDRAWAL OF CONSENT

This Consent may be revoked by the person giving authorization by signing or dating the revocation statement below or through written notice except to the extent that action has been already taken in reliance hereon. If not earlier revoked, this consent shall automatically terminate one year after the date signed above without express written revocation.

On this day, _____ of 20___ , I revoke the above Consent To Release Information.

_____
Patient/Parent/Legal Representative Date