Patricia D. Post, Ph.D.
Jodie Guth, Ph.D.
Jacquelyn Braud, Ph.D.
Jerry Whiteman, Ph.D.
Samantha Whatson, Psy.D.
Brenda LaFleur, L.C.S.W.
Alice P.Williams, L.P.C., L.M.F.T.
Brenda Hollenbeck, L.P.C., L.M.F.T.

Authorization to Release Information
Between Two Parties

Patient:____
Date of birth:____________________ SS#:_____________________

By my signature below, I authorize the exchange of verbal and written clinical information between the following two parties:

1. Physician/Professional:_______________________________________
at
The Psychology Clinic
2000 Southwood Drive
Lake Charles, LA 70605

2. Name:____

Address:____

____

The information to be exchanged includes, but is not limited to, treatment history, current clinical status, diagnosis, treatment plans, and progress in treatment.

I understand that I may revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance upon it. In consideration, I hereby release the above parties from any and all liability arising therefrom.

This authorization, unless expressly revoked earlier, expires one year from the current date.

_____________ ________________________________ __________________
Date Signature Relationship to Patient

_____________ ____
Date Witness Signature