Patricia D. Post, Ph.D.
Jodie Guth, Ph.D.
Jerry Whiteman, Ph.D.
Jacquelyn Braud, Ph.D.
Brenda LaFleur, L.C.S.W.
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 Client

_____ _____
Date Witness