John Gould, PhD

Clinical Psychology

3660 Stoneridge Rd.
Unit F-102
Austin, Texas 78746

t: 512-576-5052
f: 512-519-4307
e: john@johngouldphd.com

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____

_____

I hereby authorize _____
(school/facility/physician/hospital and address)

_____

to release to and/or receive from: Dr. John Gould

3660 Stoneridge Rd., Unit F-102

Austin, Texas 78746

the following specified information:

- ☐ Progress Notes
- ☐ Psychosocial Assessment
- ☒ Psychological Evaluation
- ☐ Neuropsychological Evaluation
- ☐ Treatment Plans
- ☐ Behavioral Rating Scale/Problem List
- ☐ School Records
- ☒ Other: Clinical Information

The information will be used for the following purpose:

- ☒ Psychological Evaluation
- ☐ Continuity of Care and Treatment
- ☐ Settlement of Insurance Claim
- ☐ School Requirement
- ☐ Other: _____

I understand I can revoke this authorization at any time, except to the extent that action has been taken and, if not earlier revoked, it shall expire on the following date or if not specified, in six (6) months from the date signed.

_____
(date, event, or condition upon which consent will expire)

I understand that the specific type of information to be disclosed may include a history of DRUG and/or ALCOHOL ABUSE and/or MENTAL HEALTH TREATMENT.

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent/Legal Guardian Date

_____ _____
Signature of Witness Date