

LAUREN JORDAN, LCSW, CST
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214-692-6100

CONSENT FORM FOR RELEASE OF CONFIDENTIAL INFORMATION

Client Name _____
Address _____

The release or exchange of information shall be to the individual or agency listed below:

TO: _____ FROM: _____

I authorize Lauren Jordan, LCSW, CST as my therapist, to release and/or receive the following confidential information as deemed pertinent to my therapy. I understand that I can revoke my consent at any time by written notice.

- Phone consultation with physician _____
- Phone consultation with attorney _____
- Release copies of my records _____
- Release dates of attendance _____
- Release diagnosis _____
- Brief letter to physician regarding therapy _____
- Other _____

This authorization for the exchange of information is made with informed consent. A photographic copy of this authorization will be considered as effective as the original.

Signature of client _____
Date _____