Dannie R. Volek, MEd.,LPC-S
Cross Point Counseling
104 W. 4th Street
Taylor, TX 76574
Phone: 512-352-3207 Fax: 512-352-3208

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize you to release the following information from the records of:

Client Name: _____

Date of Birth: _____

Social Security Number: _____

Information to be released:

To/From: _____ From/To: **Dannie R. Volek, MEd., LPC-S**

_____ 104 W. 4th Street, Taylor, TX 76574

_____ Phone: 512-352-3207 Fax: 512-352-3207

Information Requested:
____Psychological History Evaluation
____Psychological Testing Reports
____Psychiatric Evaluation
____Information of Client's Classroom/School Behavior
____Treatment Summary
____Intellectual/Educational Assessments/ARD Reports
____Other: _____

Purpose of disclosure: Treatment Planning

I understand that I may revoke this authorization at any time except to the extent that action has already been taken in reliance hereon and if not revoked sooner in writing this authorization will expire 90 days from the date signed unless a longer period Is needed for payment of claim then after fulfillment of legal and/or contractual agreement with any third party payer. I hereby release the person/organization releasing information from any liability which may arise as a result of the use of the information contained in the copies of the records released. I further understand the provision of current services is not contingent on my decision to release this information.

To the receiving party of this information: This information has been disclosed to you for the sole purpose stated in this authorization and any other use of this information without the expressed written consent of the client is prohibited. These records may be protected by federal regulation (42CFRPart2). Please destroy or return copies after used for stated purpose.

_____ _____
Client Signature Date Signed

_____ _____
Guardian/Authorized Representative Signature Date Signed