PELTS, KIRKHART & ASSOCIATES, LLC

DANA BROUSSARD LABAT, Ph.D.
Clinical Psychologist

REQUEST FOR RELEASE OF CONFIDENTIAL INFORMATION

I authorize *Pelts, Kirkhart, & Associates* to request/release information regarding services for the client below:

Client Name: ______________________________ **Date of Birth:** ____________________

Address: ____

City/State/Zip: ______________________________ Telephone: (_________) ______________

This information is requested for the following purposes:

____

Records are specified to include the following:

- Telephone consultations ☐ Yes ☐ No
- Written consultations ☐ Yes ☐ No
- Questionnaires ☐ Yes ☐ No

Records (specify):
____
____
____

Faxing of records is approved: ☐ Yes ☐ No

This authorization is specific to the following provider(s):

Name/School/Organization: ____

Address: ____

City/State/Zip: ____

Telephone: (_________) ________________________

______________________________ Print Name

______________________________ Witness Date

______________________________ Signature Date

To revoke this release, the client/legal guardian can submit such request in writing.

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