RECIPROCAL CONSENT TO EXCHANGE INFORMATION AND RECORDS

Client's Name: ____ Date of Birth: _____/ _____/ _____

I, ______________________________, hereby consent to the release of privileged information and records and waive the privilege of confidentiality afforded for medical and mental health care, alcohol and drug rehabilitation and authorize:

Frisco Behavioral Health Group, LLC
Rebecca Phipps, LPC
4500 Hillcrest Road Suite 115
Frisco, Texas 75035
(469) 213.6400
and

____
Name

____
Address

____________________________________ ____________________________________
Phone Fax

To exchange reciprocal information and records for the purpose of clarifying and enhancing my care and treatment including but not limited to:

__________ Psychiatric Evaluations
__________ Psychological and / or Academic Testing
__________ Diagnosis, treatment Plan and Progress Notes
__________ Parent Consultations (if the client is a minor)
__________ Other: ______________________________

Swati Ellendula, M. D. is hereby released from any and all liability arising out of, or in any way incidental to, producing records or providing information pursuant to this authorization. (A duplicate, phot static copy or facsimile reproduction of this authorization may be used in lieu of the original.) This authorization is subject to revocation in writing only by the undersigned.

Signature: ______________________________ Print Name: ____________________________

Relationship to Client: __________________________ Date: _____________________________