**Jim LeFan, Ph.D.**

[DrJimLeFan.com](http://www.drjimlefan.com/)

**Psychotherapy, Assessment, and Consultation**

[jimlpsych@icloud.com](mailto:jimlpsych@icloud.com)

3536 Bee Caves Road, Suite 204

Austin, Texas 78746

512-328-9632 phone/fax

**Authorization For Release of Exchange of Information**

Print Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB: \_\_\_/\_\_\_/\_\_\_\_

**Information only released to or exchanged with:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Information to be exchanged or released:**

\_\_\_ Psychological Test Results \_\_\_ Diagnosis

\_\_\_ Psychological Evaluation(s) \_\_\_ Medical Record(s)

\_\_\_ Mental Status \_\_\_ Family System Evaluation(s)

\_\_\_ Treatment Plan(s) \_\_\_ Consultation Report(s)

\_\_\_ Progress Notes \_\_\_ Educational Test(s) or Report(s)

\_\_\_ Therapist Orders \_\_\_ Attendance Records

\_\_\_ Psychosocial Reports \_\_\_ Other

Patient Signature (or guardian, if required)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date\_\_\_\_\_\_\_\_\_\_