Cornerstone Assessment & Guidance Center, LP

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CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

I authorize Beth Lusby, PhD and/or Kristin Rose, PsyD to (check one or both below)**:**

_____release the information checked below _____receive information checked below

	Summary of Assessment and Treatment		Testing Report/Diagnostic Assessment
	Diagnostic Impressions		Verbal Exchange: All Clinical Information
	Notes of Clinical Record		Other:
	School Records/IEP		

for:_____ **Date of Birth:**_____
(Name)

to/from:

Name/Agency:	
Address:	
Phone Number:	
Fax:	

For the purposes of (check all that apply)**:**

	Treatment Planning		Coordination of Services
	Continuity of Care		Other:

I am signing this consent under the following conditions:

a. My judgment is neither impaired by emotional duress nor any chemicals.
b. I may withdraw this authorization, in writing, at any time except to the extent that action has previously been taken thereupon.
c. If not withdrawn, this authorization expires one year from the date below unless revoked in writing.
d. That upon expiration of this release neither agency nor practitioner will discuss information pertaining to me without my further consent except for communication with any insurance company which I have separately authorized.

_____ _____
Signature of patient or parent/guardian (if patient is a minor) Date