

GARY M BARNARD, Ph.D.
LICENSED PSYCHOLOGIST
CHILD, ADOLESCENT & ADULT
13535 JONES-MALTSBERGER RD
SAN ANTONIO, TEXAS 78247
PHONE: 210/496-5437 FAX: 210/496-2804

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

PATIENT'S NAME: _____ BIRTHDATE: _____

I hereby give my permission for _____
to release any confidential information, verbal or written,
regarding the above-name individual to include:

Information to be released to:

I understand that the information obtained will be treated
in a professional and confidential manner, and will not be
re-disclosed to any other person or agency without the
written consent of the above-named person and/or parent or
guardian.

This consent expires ninety (90) days from the date of the
signature.

PATIENT'S SIGNATURE (if necessary)

DATE

PARENT OR GUARDIAN

DATE

WITNESS SIGNATURE

DATE