Kara Smith, LCSW
EMDR & Psychotherapy

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RELEASE OF INFORMATION

TYPE OF RECORDS TO BE SHARED

Specific information to be released		
☐ Complete Record	☐ Family History	☐ Treatment Summary
☐ Progress Notes	☐ Closing Summary	☐ Treatment Plan

TO BE SHARED WITH

Name			
Address	**City**	**State**	**Zip Code**
Phone Number	**Fax Number**		
( ) -	( ) -		

FOR THE PURPOSE OF

Specific purpose for which information is required	
☐ Collaborative Care, psychiatry	☐ Transition from new provider
☐ Collaborative care, healthcare professional	☐ Transition to new provider
☐ Other: _____	☐ By client special request

BY THE FOLLOWING

Client Name			Phone
			( ) -
Address	**City**	**State**	**Zip Code**

This document shall **remain in effect for one year from date of signature**, unless revoked by the undersigned. This release is subject to revocation by the undersigned at any time except to the extent that action has already been taken in reliance thereon. Revocation must be submitted in writing. The undersigned is aware that material released by Kara Smith, LCSW, may contain information about treatment received for alcohol/drug abuse and/or mental illness.

Kara Smith, LCSW is not responsible for confidential information which is passed on to any party not named in this released.

I authorize the release of information from the above individual/institution to: Kara Smith, LCSW 2990 Richmond Ave, Ste 630 Houston, TX 77098	**Client Signature**	**Date**

I authorize Kara Smith, LCSW 2990 Richmond Ave, Ste 630 Houston, TX 77098 to release information to the above named individual/institution.	**Client Signature**	**Date**

Witness Signature	Date