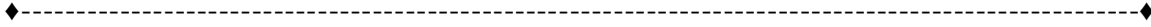


Linda Brase, M.A, LPC

4131 Spicewood Springs Road, Suite L-4
Austin, TX 78759
512.496.4848



CONSENT FOR RELEASE OF CONFIDENTIAL PATIENT INFORMATION

This consent authorizes Linda Brase, M.A., LPC or her representative to release the below specified information about:

Name	Date of Birth	Social Security Number
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To:

Recipient's Name

Recipient's Contact Information

For the purpose of: (Please initial)

<input type="checkbox"/> Insurance Claim	<input type="checkbox"/> Continuity of Care
<input type="checkbox"/> Completing Clinical Assessments	<input type="checkbox"/> Treatment of Minor Child
<input type="checkbox"/> Treatment Planning and Coordination	<input type="checkbox"/> Referral
<input type="checkbox"/> Legal Action	<input type="checkbox"/> Other (specify) _____

Information to be disclosed: (Please initial)

<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Treatment Plan
<input type="checkbox"/> Verbal Communication	<input type="checkbox"/> Other (specify) _____
<input type="checkbox"/> Summary of Entire Record	

Consent expires on: _____

I understand that I may refuse to release my record. I understand that I may revoke this consent in writing at any time except to the extent that action has already taken place. I understand that Linda Brase has no control over my records once they are released to a third party. I understand I have a right to a duplicate of this form for my record.

Patient Signature	Date Signed
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Legally Qualified Representative	Relationship to Patient	Date Signed
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Witness Signature	Date Signed
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COMPLETE ONLY IF YOU WISH TO HAVE YOUR CARE CO-ORDINATED WITH ANOTHER HEALTHCARE PROVIDER