David K. Cox, Ph.D.
Therapy With Direction

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AUTHORIZATION OF CLINICAL RELEASE OR TO OBTAIN CONFIDENTIAL INFORMATION

I, _____, give permission to David Cox, Ph.D., LMHC to ☐ release or ☐ obtain information to the party listed below pertinent to clinical records and information regarding treatment issues on my behalf, or on behalf of the minor child listed below for whom I am responsible.

I request that the information be ☐ released to ☐ obtained from:

_____

_____

Client Information:

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Reason for ☐ Releasing Information: ☐ Obtaining Information:

_____

_____

_____

I hereby release David Cox, Ph.D., LMHC, David K. Cox, LLC and its authorized representatives from all legal responsibility for the retrieval and release of information described in this authorization.

Client: _____ Date: _____

Parent/Guardian: _____ Date: _____

Witness: _____ Date: _____

This authorization is valid for 180 days from the date of the client's signature above.