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## Request/Authorization to Release Confidential Records and Information

I hereby authorize:

Person or facility:

\_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

to release information from records about \_\_\_\_\_, born on \_\_\_\_\_,  
and whose Social Security number is \_\_\_\_\_, for the following purpose(s):

- Further mental health evaluation, treatment, or care  Rehabilitation program development or services  
 Treatment planning  Research  Other: \_\_\_\_\_

These records concern the time between \_\_\_\_\_ and \_\_\_\_\_.

The information to be disclosed is marked by an "X" in the boxes below, and the items not to be released have a line drawn through them. Page numbers are indicated when appropriate. Written dates indicate when those records were mailed to the requestor.

- Intake and discharge summaries  Medical history and evaluation(s)  
 Mental health evaluations  Developmental and/or social history  Educational records  
 Progress notes, and treatment or closing summary  Other:

Select only one:

- Please forward the records to the address in the letterhead at the top of this form.  
 Please forward the records to the address written above.

HIV-related information and drug and alcohol information contained in these records will be released under this consent unless indicated here:  Do not release.

I have had explained to me and fully understand this request/authorization to release records and information, including the nature of the records, their contents, and the consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may take back this consent at any time within 90 days, except to the extent that action based on this consent has already been taken. This consent will expire automatically after 90 days from the date on which it is signed, or upon fulfillment of the purposes stated above.

\_\_\_\_\_  
Signature of client Printed name Date

\_\_\_\_\_  
Signature of parent/guardian/representative Printed name Relationship Date

I witnessed that the person understood the nature of this request/authorization and freely gave his or her consent, but was physically unable to provide a signature.

\_\_\_\_\_  
Signature of witness Printed name Date

- Copy for patient or parent/guardian  Copy for source of records  Copy for recipient of records