

# *Misty K. Hook, Licensed Psychologist*

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## AUTHORIZATION TO RELEASE CONFIDENTIAL RECORDS AND INFORMATION

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I hereby authorize: **Misty K. Hook, Ph.D.**

Address: **101 W. McDermott, Suite 119; Allen, TX 75013**

To release information from records about \_\_\_\_\_ to the following entity or individual \_\_\_\_\_ for the following purpose(s):

- Further mental health evaluation, treatment, or care
- Treatment planning
- Other (specify): \_\_\_\_\_

The information to be disclosed is marked by a  in the boxes below.

- Mental health evaluations
- Developmental and/or social history
- Progress notes, and treatment or closing summary
- Other: \_\_\_\_\_

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 one year, except to the extent that action based on this consent has already been taken. This consent will expire automatically after one year from the date on which it is signed, upon fulfillment of the purposes stated above, or upon receipt of a written and signed statement rescinding consent sent to the letterhead address.

Signature of client	Printed name	Date	

  

Signature of parent/ guardian/representative	Printed name	Relationship	Date