Behjat Shirazi, MA LPCC
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CONSENT FOR EXCHANGE OF CONFIDENTIAL INFORMATION

I, ______________________________, hereby authorize Behjat Shirazi, MA, LPCC to exchange information (about my/child's case) with:

Name and Title____
Address: ____
Phone #:________________________ Email: __________________________

For the purpose of:

( ) Continuing evaluation and treatment
( ) Disability determination
( ) Insurance claim
( ) Other_____________

Information to be disclosed:

( ) Discharge Summary
( ) Treatment plan
( ) Consultations
( ) Case history and progress notes
( ) Psychiatric evaluation
( ) Psychological evaluation
( ) Psychological/academic tests
( ) Other________________

Information is to be communicated in the following manner:

( ) in writing, email, including copies of records
( ) By phone

I understand that I can revoke this consent at any time, except to the extend that action has already been taken. This consent will expire in 90 days from the date signed, or at the time that it is revoked in writing by me only. I understand that I have the right to examine and copy any information that is disclosed; unless it is in professional opinion that such disclosure is not in my best interest.

To the receiving party of this information:

This information has been disclosed to you for the sole purpose stated in this consent form. Any other use of this information without the expressed written consent of the client named above is prohibited.

Client /minor name: __________________________________ Date: ______________
Client/Guardian Signature: ____________________________ Date: _____________
Witness: ____ Date: _____________

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