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AUTHORIZATION TO DISCLOSE PSYCHOLOGICAL/PSYCHIATRIC INFORMATION

If you sign this form, confidential psychological and psychiatric information can be released to and/or discussed with the people or agencies listed below unless noted by exclusions or limitations. This form is being signed voluntarily and you may change your mind at any time. All disclosures made pursuant to this form are valid as long as they were made before the date of revocation.

I give permission for Dr. Bird to exchange information with:

NAME	ADDRESS	PHONE/FAX
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

regarding contact with me (or my minor child). _____

NAME OF PATIENT

____/____/____
Date of Birth

I understand that this information is psychological, medical, social, educational, or otherwise clinically relevant in nature and may include results of evaluation and clinical assessment, psychological data, reports, and/or evaluations and after-the-fact evaluations, as well as business transactions including accounts, billing, and insurance. I understand that I can specifically limit the information provided by listing the limitations below. Permission will continue until revoked in writing.

Date

Signature of Patient

Signature of Parent or Guardian (if minor)

Witness

Limitations _____
