Kristen Chambliss, Ph.D.

1560 W. Bay Area Blvd., Suite 270, Friendswood, Texas 77546 Ph: (281) 480-0200 Fax: (281) 480-0202

I, (Name)_____, hereby authorize and request Dr. Kristen Chambliss to exchange and release the following information, both verbally and in written format.:

[ ] Progress Notes

[ ] Psychological Evaluation Information

[ ] Client Contact Information

[ ] Pertinent Clinical and Demographic Information

The following individuals may receive this information with my consent:

[ ] _____ (name of agency)

[ ] _____ (name of physician)

[ ] _____ (name of spouse/partner)

[ ] _____ (name of intended parents)

I understand that I am under no obligation to disclose the requested information and that I may revoke my consent at any time by informing the above named individuals in writing.

I further understand that this authorization is valid for only one year from the following date.

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date