RECIPROCAL CONSENT TO EXCHANGE INFORMATION AND RECORDS

Client's Name: _____ Date of Birth: _____/ _____/ _____

I, _____, hereby consent to the release of privileged information and records and waive the privilege of confidentiality afforded for medical and mental health care, alcohol and drug rehabilitation and authorize:

Sadaf Noor, M. D.

1400 Coit Rd, Bldg 22, Ste 2204
McKinney, TX 75071
Tel: 469-397-4234 Fax: 469-319-8363

4300 Punjab Way, Unit #140
Frisco, TX 75034
Tel: 469-530-2244 Fax: 469-804-9311

303 S. Highway 78, Suite 103
Wylie, TX 75098
Tel: 469-361-3406

_____
Name

_____
Address

_____ _____
Phone Fax

To exchange reciprocal information and records for the purpose of clarifying and enhancing my care and treatment including but not limited to:

_____ Psychiatric Evaluations
_____ Psychological and / or Academic Testing
_____ Diagnosis, treatment Plan and Progress Notes
_____ Parent Consultations (if the client is a minor)
_____ Other: _____

Sadaf Noor, M. D. is hereby released from any and all liability arising out of, or in any way incidental to, producing records or providing information pursuant to this authorization. (A duplicate, photo static copy or facsimile reproduction of this authorization may be used in lieu of the original.) This authorization is subject to revocation in writing only by the undersigned.

Parent/Legal guardian signature: _____Print Name: _____

Relationship to Client: _____ Date: _____