



*North Texas Family Services
Lauren Gordon, LCSW*

Lauren Gordon, LCSW
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Release of Information

Directions: Please include yourself and any minor children you have legal responsibility for (conservatorship, guardianship, “custody,” etc.). Please use additional copies if needed.

Client(s): _____ DOB _____
_____ DOB _____
_____ DOB _____
_____ DOB _____

The signature below hereby authorizes and requests the release of any and all records pertaining to the following:

<input type="checkbox"/> MEDICAL	<input type="checkbox"/> POLICE/CRIMINAL RECORDS	<input type="checkbox"/> PROBATION/PAROLE
<input type="checkbox"/> DENTAL	<input type="checkbox"/> THERAPY/COUNSELING	<input type="checkbox"/> SUBSTANCE ABUSE
<input type="checkbox"/> SCHOOL	<input type="checkbox"/> PSYCHIATRY/PSYCHOLOGICAL	<input type="checkbox"/> OTHER
<input type="checkbox"/> DAYCARE	<input type="checkbox"/> CPS	

These items are to be provided to Lauren Gordon, LCSW with North Texas Family Services for the purpose of a court ordered evaluation. This consent is valid for one year from the date of signing. The client grants authorization for the release of records and will be responsible for the any fees incurred from the request.

Signature of Client (for self and minor children) Date

Signature of Guardian or Personal Representative Date

** If you are signing as a personal representative of another individual please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).*