CHRISTIAN LIFE COUNSELING

AUTHORIZATION to RELEASE/EXCHANGE INFORMATION

Name of Provider/Representative:_____
Christian Life Counseling
25132 Oakhurst Dr., Suite 185
Spring, TX 77386
Phone: (281) 419-2323 Fax: (281) 419-0744

The above named clinic/person is authorized to release and/or obtain information regarding:

_____

TO/FROM:

Agency/Person:_____

Phone Number:_____ Fax Number:_____

Address:_____

Information to be released:_____

The purpose of the disclosure is (check appropriate items):

____ To assist in this individual's evaluation and treatment
____ To obtain information
____ Other (specify):_____

I understand that all patient information is confidential and is protected under Federal Confidentiality Regulations and cannot be disclosed without written consent unless otherwise provided for in the regulations. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. Without my expressed revocation, this authorization will automatically expire:

____ Upon receipt of the information requested
____ After 6 months of date of signing
____ Upon termination of services
____ On _____ (date supplied by client)
____ Other:_____

I further acknowledge that the information to be released/exchanged was fully explained to me.

_____ _____
Signature of patient or legal guardian Date

_____
Relationship to client