9525 Katy Freeway, Suite 312
Houston, Texas 77024
Phone: (713) 463- 9449
Fax: (713) 463 7181

Authorization to Release Information

I, ____ authorize

____ and

____
(name of person(s) or organization(s) which disclosure is to be made to and/or received from)

to disclose or release **one to the other** the following information from my records:

_______ All Health Care Information

_______ Health Care Information or Opinions Relating to any or all of the following treatment(s) and , or conditions:
_____1) Psychiatric or Mental Health Information
_____2) Academic and Confidential School Information
_____3) Testing
_____4) Other ______________________________________

For the purpose of treatment/management and or supervision or psychological and or medical condition(s), **I hereby waive my right to the privileges of confidentiality as specified above, for a period of one year after termination of treatment, management or supervision unless expressly revoked earlier in writing.**

_____________________________________ _____________________
Client Date

_____________________________________ _____________________
Parent or Legal Guardian Date

_____________________________________ _____________________
Witness Date