corbella
individual • couples • family • play therapy

AUTHORIZATION to RELEASE CONFIDENTIAL INFORMATION

Name of Client: _____

I hereby authorize: Kaitlin Sutherlin M.S., LPC-Intern, and Corbella Counseling **at 4849 Greenville Ave Ste 1100, Dallas, TX 75206**

To communicate with or release confidential information to:

Individual(s) Name: _____

Organization Name: _____

Phone: _____ ***Email:*** _____

In the following manner (check all that apply)

_____ to release written records

_____ to release information verbally

_____ to request information

The information to be used will be limited to the following (check all that apply)

_____ verbal or written communication between professionals

_____ dates of treatment attendance

_____ other (specify) _____

_____ test results

_____ diagnosis

_____ session notes

The information will be released via written documents, and copies will be available at the office for pick-up (only) in one week from receipt of signed authorization to release confidential information.

The reimbursement for copies of provider records is ten dollars for the first ten pages, and thirty-three cents for each additional page. These fees are due upon pickup of records and are the responsibility of each receiving party.

I understand that if I am signing as the parent of a minor or as a guardian, the release may contain references to myself and my family. I understand that I may revoke this consent to release information at any time prior to the stated expiration above. I also understand that any release made between the time I authorized it and then revoked it shall not constitute a breach of my right to confidentiality.

This consent will automatically expire one (1) year after the date of my signature as it appears below.

_____

client signature **Date**

_____

parent/guardian if child is a minor **Date**