



**AUTHORIZATION to RELEASE CONFIDENTIAL INFORMATION**

Name of Client: \_\_\_\_\_

I hereby authorize: Corrie Bright 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 \_\_\_\_\_ test results

\_\_\_\_\_ dates of treatment attendance \_\_\_\_\_ diagnosis

\_\_\_\_\_ other (specify) \_\_\_\_\_ 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