5870 Highway 6 North, Suite 310. Houston, TX 77084. Phone: 281-299-8607
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Life Cycles Counseling, PLLC

Authorization to Release Mental Health Records

Mental health records to/from:

Life Cycles Counseling
5870 Highway 6 N, Suite 310
Houston, TX 77084

Mental health records to/from:

Permission to disclose the following information:

____ Therapy Notes ____ Dates of Services ____ Billing and Charges for Services
____ Diagnosis ____ Assessments ____ Information Related to Drugs and Alcohol
____ Medical Information ____ Progress in Therapy ____ Discharge Summary
____ All clinical information pertaining to my treatment.
____ Other (please specify) _____

Can this information be released verbally?

Yes ____ No _____

Date of services: _____

Purpose of Release:

Collaboration of Care ____ Legal Proceedings ____ Financial ____
Continuity of Treatment ____ Determine Eligibility ____ Family Involvement ____
Other (specify) _____

Unless the authorization is revoked earlier, it will expire on _____

_____ _____ _____
Name of client Signature Date

_____ _____ _____
If minor, parent/guardian Date of Birth Last 4 digits of Social Security #

Instructions:

Please fill out and sign this form if you would like to receive or disclose certain information about your treatment. Examples include, but are not limited to, your doctor, psychiatrist, neurologist, spouse, son/daughter, school officials, probation officer, and clergy.

Please include as much information as possible, including name, address, phone and fax.

If you don't want anyone to have access to your treatment, please leave the form blank. If you wish for Marcel Gamboa, LPC, to verbally communicate with the person you have chosen to give consent to, please make sure you check mark "Yes" to the question "Can this information be released verbally?"

Expiration date is usually 1 year from the date of signature of this form, unless indicated otherwise by the client.

Please contact Life Cycles Counseling if you have any questions about this authorization form. Treatment records are protected under the Health Insurance Portability and Accountability Act (HIPPA) and cannot be disclosed without your written consent unless otherwise provided for in the regulations. By signing this form, you consent to the release of the information to the specified party for the specified purpose indicated above. You have the right to revoke this consent at any time in writing. You have the right to refuse to sign this information. Life Cycles Counseling will not withhold treatment or payment process if you refuse to sign this form. A copy of this form will be provided to you.