

Life Cycles Counseling

Authorization to Release Mental Health Records

Mental health records to/from:

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Life Cycles Counseling
14525 FM 529, Suite 200
Houston, TX 77095

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.