AUTHORIZATION FOR RELEASE OF INFORMATION

CLIENT NAME: _____

DATE OF BIRTH: _____

I AM AUTHORIZING THE LISTED PARTIES BELOW TO RELEASE OR DISCLOSE TO ONE ANOTHER REGARDING ME OR MY CHILD'S CASE.

The Being Place, PLLC—an integrative psychotherapy practice where you remember to breathe
Brenda Henning, M.S., LPC | 22310 Grand Corners Drive | Katy, TX 77494
Phone: 832-212-0358| E-mail: brenda@thebeingplace.net |www.thebeingplace.net

NAME: _____

ADDRESS: _____

CITY, STATE, ZIP: _____

PHONE: _____ FAX: _____

THE FOLLOWING ITEMS ARE REQUESTED: _____DISCHARGE SUMMARY_____

THE REQUEST IS MADE VOLUNTARILY FOR PROFESSIONAL PSYCHOLOGICAL PURPOSES. I CAN REVOKE THIS AUTHORIZATION BY GIVING WRITTEN NOTICE TO MY HEALTH SERVICE PROVIDER. IF NOT REVOKED, THIS FORM WILL BE VALID FOR ONE YEAR FROM THE DATE SIGNED. A PHOTOCOPY OF THIS AUTHORIZATION WILL BE VALID AS THE ORIGINAL.

_____ _____

SIGNATURE (IF CHILD, THEN LEGAL GUARDIAN) (DATE)