1075 Kinwest Parkway Suite 107 Irving, Texas 75063
Phone: 972-910-8388 Fax 972-910-8366
www.lascolinascounseling.com

Date ___________

I hereby authorize ____

To release confidential information from my counseling records or my child's counseling records to:____
(address, phone, fax) ____

The above information is released for the following purpose:

- o Continuity of Care
- o Evaluation & Treatment
- o Billing
- o Legal Communication

I understand that only such confidential information concerning the above person will be released as is considered essential to the purpose stated above. All information released by the sending organization or person shall be held as confidential by the receiving organization or person.

I understand that Las Colinas Counseling Center and its staff are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.

Client's Signature _______________________________

Client's name __________________________________

Expiration of Authorization _______________________

Parent or Legal Guardian _________________________

Witness _______________________________________