Authorization for the Release of Information
West Houston Counseling Center, PLLC
707 South Fry Rd. Katy, Texas 77450
Phone: 281-940-8515 Fax: 888-972-1582
westhoustoncounseling.com

I __________________________________, authorize __________________________________ and
client/parent) (therapist)

____
(name of person(s) or organization(s) which disclosure is to be made to and/or received from)

to disclose to one or the other the following information from (please check one):

___ my records

___my child____
(Childs name)

__________ All healthcare information
(initial here)

__________ Health Care or Information or Opinions relating to any or all of the following treatments and/or conditions:

__________ 1. Mental Health Information
(initial here)

__________ 2. Academic and Confidential School Information
(initial here)

__________ 3. Testing
(initial here)

__________ 4. Other ____
(initial here)

For the purpose of treatment/management/supervision of psychological and/or medical conditions I hereby waive my right to the privileges of confidentiality as specified above, for a period of one year after signing this release.

____ _____________________

Client Signature Date

____ _____________________

Parent/Guardian Signature Date

____ _____________________

Witness Signature Date