Transitions Counseling DFW LLC
2304 West Bardin Road Suite 202
Grand Prairie, TX 75052

CONSENT TO RELEASE INFORMATION

I _____ authorize _____,Transitions Counseling Therapy Counselor to obtain and release information from my clinical records with:

Name / Phone (Individual or Agency) _____

Name / Phone (Individual or Agency) _____

Name / Phone (Individual or Agency) _____

This includes verbal and written communication regarding treatment for the purposes of:

___Consultation, evaluation, or treatment and coordination of care services

___ Family participation in treatment and care services ___ Attendance

___ Billing / Arranging for payment ___ Medical Condition ___ School Functioning

I understand that information being released from my mental and or medical treatment is protected under Federal Confidentiality Regulations 42 C. F. R. Part 2 and HIPAA Privacy Regulation. I certify that this authorization has been made voluntarily.

This consent may be revoked in writing by the undersigned at anytime. If not revoked, this consent will expire: (3 months after last therapy service date)

Client or Guardian _____ **Date** _____

Client or Guardian _____ **Date** _____

Therapist or Witness _____ **Date** _____