Authorization For Release of Confidential Information

Name I authorize Centrapeutic Counseling, Irving, Texas and the persons entities listed below, or their representatives, to mutually release and disclose my health information. I have received and reviewed the Notice of Privacy Practices. I understand that only representative of Centrapeutic Counseling may ask me to sign this authorization. I understand by signing this General Authorization I am authorizing Centrapeutic Counseling to disclose my health information to the persons and entities listed below and that my health information or other confidential information includes without limitation, any records, reports, test results, opinions, assessments and any other information relating to medical, emotional educational or psychological condition.

Disclosure may also be made to describe my condition and progress and to discuss treatment. I further I understand that my health information may be disclosed to any person or entity providing any payment for services I receive, including insurance companies and current or future mental health counselors, psychiatrists, psychologists, Clergy or Rabbis or Imams.

I understand that I make evoke this authorization at any time by sending a written notice of revocation to Centrapuetic Counseling at the office where I am receiving counseling. I understand that my revocation of this General Authorization will not affect a disclosure that Centrapuetic Counseling has mad already made under this authorization. I understand that information used or disclosed under this authorization may be subject to re-disclosure by the recipient, and may no longer be protected by the confidentiality rules of Centrapeutic Counseling. I waive my right to privacy that I may have in connection with the disclosures hereby authorized.

This authorization is only valid until_____ [date] or until three months after my file is closed by Centrapeutic Counseling, Irving, Texas.

Name_____

_____

Address

_____

Client Initials _____ Client Signature Date

_____

Signature of parent or guardian (if client is under 18)

_____ Date _____

Therapist Date_____

Date_____