



AUTHORIZATION/CONSENT For Release of Confidential Information

I, _____, born _____, authorize Daehnert Counseling LLP (101 W. McDermott Allen, TX 75013) to disclose my/my child's records to the individual or group specified below:

- Hospital
- Psychiatrist (M.D.)
- Psychologist
- LPC, LPC Intern
- Insurance Company
- Other: _____.

Contact Name: _____ Organization: _____

Address: _____ City, State, Zip: _____

The disclosure of records authorized herein is required for the following purpose:

- Court Subpoena
- Personal Review
- Therapist Consultation
- Insurance Reimbursement
- Other Care: _____

The following specific types of information are requested:

- All Records
- Records from _____ to _____

This authorization shall remain in effect from _____ (mm/dd/yy) to _____ (mm/dd/yy) or check here _____ for indefinitely.

I understand that I am giving consent for the release of my records from Daehnert Counseling LLP only to/from the above named organization/person for the time shown above. I understand that, with a few limited exceptions, Daehnert Counseling LLP may not release records and/or information about myself/my child unless I agree to the request. I understand that I cannot withdraw consent for actions that have already taken place before I withdrew my consent. The information, which is being disclosed, is from records whose confidentiality is protected by Federal Law. *This consent is subject to revocation, in writing, at any time but such revocations have no effect of disclosures previously made. I further release Daehnert Counseling LLP of any liability related to the confidentiality of and release of the information identified in this release.*

Client Signature: _____ Date: _____

Parent/Guardian Signature: _____ Printed Name: _____ Date: _____

Staff Signature: _____ Date: _____