Christian Counseling Associates
2001 W. Plano Pkwy, Suite 2300
Plano, TX 75075

Authorization for Release of Information

I hereby authorize _____

Located at _____ Telephone # _____

to release to _____ the following information on:

_____ _____
(Client name) Client's Date of Birth

Information to be released: (Please check all that apply)

_____ Hospital psychological records
_____ History & Physical
_____ Phone consultation
_____ Educational records
_____ Psychological tests
_____ Psychological evaluation
_____ All information related to past & current psychotherapy, mental health, substance abuse, medical information (including AIDS related), and all treatment (including hospital in-patient care)
_____ Other: _____

EXCLUDE: _____
(specify any information you DO NOT want released)

The above information is released for the following purposes: evaluation, treatment planning, EAP & Managed Care requirements, payments, _____

Any other use is forbidden.

I understand that my records are protected under the Federal Confidentiality Regulations and cannot be disclosed without my written authorization unless otherwise provided for in the regulations.

I may revoke this authorization at any time. Withdrawal of this authorization does not affect any information disclosed prior to written notice of the withdrawal.

This authorization will expire NINETY (90) DAYS from the date of my signature or as otherwise specified by date, event, or condition, as follows: _____

_____

Date: _____ Signature: _____
(Client or legal representation)

Signature of minor (if applicable) _____ Relationship to client _____

Witness: _____ Date _____