**Erin Silva, M.Ed., LPC**

**Tranquil Hearts Counseling Center**

17920 Huffmeister Rd, Suite 250

Cypress, TX 77429

(281)433-1363

**AUTHORIZATION TO RELEASE INFORMATION**

I, \_\_\_\_ , authorize Erin Silva, M.Ed., LPC and

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
(Address) (Phone Number)

to disclose or release **one to the other** the following information from my records:

\_\_\_\_\_\_\_\_\_\_ All Health Care Information

Initials

\_\_\_\_\_\_\_\_\_\_ Health Care Information or Opinions Relating to any or all of the

Initials following treatment(s) and/or conditions:

\_\_\_\_\_\_\_\_\_\_ 1. Psychiatric or Mental Health Information

Initials

\_\_\_\_\_\_\_\_\_\_ 2. Academic and Confidential School Information

Initials

\_\_\_\_\_\_\_\_\_\_ 3. Testing

Initials

\_\_\_\_\_\_\_\_\_\_ 4. Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Initials

For the purpose of treatment/management and/or supervision or psychological and/or medical conditions(s), **I hereby waive my right to the privileges of confidentiality as specified above, for a period of one year after termination of treatment, management or supervision unless expressly revoked earlier in writing.**

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PATIENT DATE

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PARENT OR LEGAL GUARDIAN DATE