**Alison Lampton, M.Ed., LPC**

**Tranquil Hearts Counseling Center**

16712 Huffmeister Rd, Building 400B

Cypress, TX 77429

(832)630-0777

**AUTHORIZATION TO RELEASE INFORMATION**

I, \_\_\_\_ , authorize Alison Lampton, 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.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
PATIENT DATE

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PARENT OR LEGAL GUARDIAN DATE