

Transitions Counseling Center
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Houston, Texas 77079
Tel 281-597-9291 ♦ Fax 281-597-9761

_____ **Kevin P. Glasser, MA, LPC**
_____ **Sandra P. Glasser, M.Ed, LPC**

_____ **Donica L. Jones, MA, LPC**

REQUEST FOR AND AUTHORIZATION TO RELEASE RECORDS AND INFORMATION

Patient Date of Birth: _____

Patient Identification Number: _____

I hereby authorize the above therapist and/or

(Name of Person or Facility: Hospital, Clinic, School, Professional, etc.)

(Address, Phone number)

to release information from the records of _____
(Patient's or Child's Full Name)

and to send them to the therapist who is listed on this letterhead or to the professional or facility listed on the line just above for the purposes(s) of **(initial each item to be released)**:

- _____ Further mental health/psychological/psychiatric evaluation, treatment or care,
_____ Rehabilitation program development or services, _____ Treatment planning,
_____ Other _____

The following information from the records is to be released **(initial each item to be released)**:

- | | |
|--------------------------------------|--|
| _____ Intake and Discharge Summaries | _____ Medical History and Evaluation(s) |
| _____ Psychological Evaluations | _____ Developmental and /or Social History |
| _____ Educational records | _____ Progress Notes and Treatment Summary |
| _____ Other: _____ | |

These records concern the time between _____ and _____

I fully understand this Authorization and Request to Release or Obtain Records and Information from my records as to the nature of the records, their contents, the consequences and implications of its release, and my request is wholly voluntary on my part. I hereby release the source of these records from any liability arising from their release. I authorize the parties above to talk by telephone about my referral, diagnoses, treatment, and similar topics relevant to the above listed purposes for this release of records. I understand that provision of services is not contingent upon this releasing of records.

I understand that I may revoke this consent at any time except to the extent that action based on this consent has been taken. This consent will expire automatically after 180 days from the date on which it is signed, or upon the fulfillment of the above purposes.

Signature of Patient

Date

Signature of Parent/Guardian/Representative

Relationship

Date