Phases Counseling & Mental Health Services, PLLC
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5787 South Hampton Road, Suite 230-K, Dallas TX 75232
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www.phasescounseling.com

Authorization to Release/Receive Client Information

Phases Counseling & Mental Health Services, PLLC has my authorization to:
☒ Release information to
☒ Receive information from

Name: _____ _____

Address: _____

Phone #: _____

Relationship to Client: _____

Information to be released:

☐ Diagnosis ☐ Prognosis ☐ Biopsychosocial ☐ _____

Purpose of Disclosure: _____

Methods of Disclosure:

☐ Phone ☐ Fax □ Mail ☐ Other __email_____

I understand that I have the right to revoke my authorization at any time and that I may do so by contacting my therapist at Phases Counseling and revoking my authorization(s) in writing. I understand that no data transmission via a telephone line or internet can be guaranteed to be 100% secure, and while the therapist strives to protect your personal information, the therapist cannot guarantee or warrant its complete security. This authorization is valid from_____ to _____.

Client Name (print): _____

Client Signature: _____

Date: _____

Therapist Signature: _____

Date: _____