



801 E. Plano Parkway Ste 150
Plano, Texas 75074

Authorization for Release of Records or Information

I, _____ hereby give permission to
Name Social or B-day

Fletcher Counseling, Inc, to disclose to and converse with _____
about:

_____ My entire record; or

_____ specified information limited to _____.

I may revoke this consent at any time by writing to the holder of the information except to the extent that action has been taken in reliance upon it. If I do not revoke it, this consent will expire in one year after I have terminated treatment. I understand that the specific information to be disclosed may include history of drug and alcohol abuse or mental health treatment, information concerning communicable diseases such as HIV and AIDS, treatment progress, and any other such related, but will not include psychotherapy notes. I understand that I may withdraw or revoke my permission at any time by notifying Fletcher Counseling, Inc & Associates in writing.

My treatment will not be based on the completion of this authorization form. The information to be released by this authorization may be re-released by the person or organization that receives it and may no longer be protected by Federal or Texas privacy regulations.

I release Fletcher Counseling, Inc & Associates from legal responsibility or liability for the disclosure of the records as authorized on this form. I understand that this authorization is voluntary and that I may refuse to sign it. I will be provided a copy of this signed authorization, if requested. A photocopy of this authorization is as valid as the original.

Signature of Patient

Date

Signature of parent or representative