Cicelia Como, M.A., LPC-Intern
Supervised by Debbie Edmunds, MA, LPC-S
www.H.O.P.E.PsychotherapyOfHouston.com

Authorization to Release Information

I, ____authorize

Cicelia Como, M.A., LPC-Intern ______________________________________ and

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

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 following treatment(s) and, or conditions:
Initials

______ 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 condition(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

_____________________________________ _____________________
Parent or Legal Guardian Date

_____________________________________ _____________________
Witness Date