M. Kirstine Benoit, MEd, LPC
Houston, Texas Phone: (832) 422-6013

AUTHORIZATION FOR RELEASE OF INFORMATION

I, ____, authorize M. Kirstine Benoit and

____

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

____

Contact number, and/or email address of person/organization which disclosure is to be made.

to disclose or release the following information from my records to each other:

______ 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 (please list specifically) ____
Initials

For the purpose of treatment, I waive my right to the privileges of confidentiality as specified above, for one year after termination of treatment, unless expressly revoked earlier in writing.

____ __________________
Client Date

____ __________________
Parent or Legal Guardian Date