SHENA TUBBS, M.MFT, LPC

Release of Information

To protect your confidentiality, I am not able to consult or release information about your care to anyone without your consent. If there are persons or agencies you would like to have permission to speak with me about your treatment (including the release of documentation), please write their names below.

I, ____, authorize and request the release information to and obtain information from the following person(s):

NAME: ____
ADDRESS: ____
CITY, STATE, ZIP: ____
PHONE: _________________________________ FAX: ______________________________

NAME: ____
ADDRESS: ____
CITY, STATE, ZIP: ____
PHONE: _________________________________ FAX: ______________________________

NAME: ____
ADDRESS: ____
CITY, STATE, ZIP: ____
PHONE: _________________________________ FAX: ______________________________

I understand that this consent is subject to revocation at any time, except to the extent that action has been taken in reliance on it. In any event, this consent shall expire one (1) year from the date signed below unless revoked earlier.

____ ______________

Signature of client (Guardian or Representative if under 18) Date