8090 Precinct Line Rd, Suite 103
Colleyville, TX 76034
Telephone: (817) 281-6822
Fax: (817) 503-1996
www.ntxcounseling.com

Release of Information

Client Name: ____ DOB: ______________

I understand by signing this form, I am allowing North Texas Counseling Associates to disclose to and/or obtain information concerning the above named client to:

____
Name of Person and/or Institution

____
Complete Mailing Address/Street/P.O. Box City/State/Zip Code

____________________________ ____
Phone/Fax Email

Description of information to be disclosed:

☐Diagnosis ☐ Participation in Treatment ☐ Progress in Treatment

☐Psychological Evaluation ☐Testing Information ☐Treatment Plan

☐Other ____

I authorize information to be released by the following methods of communication:

☐Phone ☐Fax ☐Email ☐Mail

I understand that:

- *I do not have to sign this authorization and my refusal will not affect my treatment*
- *I may **revoke** this authorization at any time by submitting a written request to NTCA*
- *This authorization will expire one year from date below.*

I certify that:

This form has been fully explained to me and I understand its contents.

____ ____________________
Signature of Client, Parent, Guardian, or Personal Representative Date

____ ____________________
Relationship if not the client Date

____ ____________________
Signature of Witness Date