Turner
COUNSELING SERVICES

7460 Warren Parkway Ste #100 Frisco, TX 75034 ● 469-223-7770 ● www.turnercounselingservices.com

Authorization for Release of Information

Client Name_____ Date of Birth_____

Mailing Address_____ Phone Number_____

_____

I give authorization to Turner Counseling Services to use or disclose information from my records, which may include diagnoses and treatment to:

Name_____ Phone Number_____

Address_____ Fax_____

_____ Relationship_____

Information to be released:

☐ Topics in sessions ☐ Substance Use

☐ Treatment Summary ☐ Medication Use

☐ Diagnoses ☐ Discharge or Transfer Summary

☐ Other (please specify) _____ ☐ Evaluations

_____

Dates of treatment covered by release_____

Purpose of Disclosure_____

I understand that this authorization shall remain valid for 180 days from the date of my signature, unless withdrawn, at which I will send a written request to Turner Counseling Services.

☐ I acknowledge that I have read and fully understand this Authorization.

_____
Client Name (Please print)

_____
Client Signature (Parent/Guardian if Under 18)

_____
Date