KoKoRo Counseling & Integrated Health Services
Healthy-Living/Wellness Training, Coaching, Counseling
P.O. Box 70494 Houston, TX 77270 PH: 832.632.8118 ; yourwellbeingmatters@gmail.com

(Fax completed form to 713.422.2428 & notify office. Fax must be received to reserve your first appointment)

GENERAL AUTHORIZATION TO RELEASE INFORMATION

I, (name of client/patient) _____, (hereinafter "Client/Patient") hereby authorize Therapist or affiliated professional of KoKoRo Counseling & Integrated Health Services, (hereinafter "Provider") to disclose mental health treatment information and records obtained in the course of counseling or psychotherapy treatment of Client/Patient, including, but not limited to diagnosis of Client/Patient to:

_____

_____(

(Print name & contact # above & relationship to client/patient. Please, only 1 Contact Person per form)

I understand that I have a right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing. I understand that I have the right to revoke this authorization at any time unless Provider has taken action in reliance upon it. And, I also understand that such revocation must be in writing and received by Provider at P.O. Box 70494 Houston, TX 77270 to be effective.

This disclosure of information and records authorized by Client/Patient is required for the following purpose:_____

_____

The specific uses and limitations of the types of medical information to be discussed are as follows:

_____

_____

Such disclosure shall be limited to the following specific types of information:

_____

_____

Provider shall not condition treatment upon Client/Patient signing this authorization and Client/Patient has the right to refuse to sign this form. Client/Patient understands that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA privacy rule, although applicable Texas law may protect such information. This authorization will remain valid for 2yrs from date of signing (see below).

Client/Patient's Printed Name: (Legible please): _____

Client/Patient's Signature: _____ Date: _____

Printed Name of Parent/Guardian: _____ _____ Date: _____

Signature of Parent/Guardian: _____ Relationship to Client: _____