

Colleen Neal, MS, LPC, NCC
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Authorization Consenting To Release of Information

I authorize (Colleen Neal LPC) to communicate (verbally or in writing) with another individual or agency (attorney, physician, probation officer, spouse, etc.) and receive any relevant information from them.

Client's Name: _____

Date of Birth: _____

I am authorizing the listed below parties to release or disclose to one another regarding my (child's) case.

Name: _____

Address: _____

City, State, Zip: _____

Telephone Number: _____ Fax Number: _____

The following items are requested:

This request is made voluntarily for professional psychological purposes. I can revoke this authorization by giving written notice to my health service provider. If not revoked, this form will be valid for one year from the date signed. A photocopy of this authorization will be valid as the original.

Signature (if child, then legal guardian)

Date

Name (print)