Ψ **CYFAIR PSYCHOLOGICAL ASSOCIATES, PLLC** Ψ
11811 F.M. 1960 W, Suite 130
Houston, Texas 77065

AUTHORIZATION TO OBTAIN / RELEASE INFORMATION

Client Information
Client Name:_____ Date of Birth: _____

Information to be Released or Received
Record(s)_____ _____
Report(s)_____ _____

Party to Disclose or Release Information
Dr. Teresa Tarver / Cyfair Psychological Associates

Party to Receive Information
Name: _____
Address: _____
_____
Telephone: _____

Authorization and Signature: I authorize the release of the confidential protected health information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected health information. This authorization will expire one year from the date signed, or as I otherwise designate.

_____

Printed Name of Client or Parent/Guardian Signature Date