Infinite Counseling & Wellness

AUTHORIZATION TO RECEIVE MEDICAL INFORMATION

Client Name _____ Date of Birth _____ Age _____ Sex ____

Legal Guardian (if child) _____

I authorize the following providers and/or individuals to receive and provide information from and to Infinite Counseling and Wellness, PLLC regarding the above named client. Method of release shall be pertinent to treatment, assessment, or legal proceedings and may include photocopies, fax copies, personal review, audio, video, electronic or verbal communication.

Name _____ Title _____

Address _____ City _____ State _____ Zip _____

Phone _____

Name _____ Title _____

Address _____ City _____ State _____ Zip _____

Phone _____

Information to be received or released (Please check all that apply)

- ▢ Complete copy of medical record
- ▢ Intake information
- ▢ Treatment plan(s)
- ▢ Therapy notes
- ▢ Discharge summary
- ▢ Psychological evaluation report

Conditions and Dates of Care Covered: All records to treatment termination date or _____

Expiration or Revocation of Authorization

I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. Without my previous revocation, this authorization will automatically end one year from the date of signature or on this specified date: _____

Signature

A copy of this authorization may be used with the same effectiveness as the original.

_____	_____	_____
Client Name	Client Signature/Legal Guardian	Date

713 907 1669
PHONE

5959 West Loop South #100 Bellaire, TX 77401
ADDRESS

ayesha@infinitecounseling.com
EMAIL