Kristi DuCote, MA, LPC, LCDC
469.688.1787

101 S. Fannin St., Ste. 105,
Rockwall, TX 75087

AUTHORIZATION TO RELEASE PERSONAL HEALTH INFORMATION*

PATIENT'S NAME:____ BIRTH DATE:__________________

I, ____, residing at ____, hereby give my consent to Kristi DuCote dba Kristi DuCote, MA, LPC, LCDC to release and receive personal health information contained in my Clinical Record regarding:

Mental health: _____ other: ___________________________
Medical history: _____ __________________________________
Family history: _____

to/from:

Recipient/Provider of Confidential Info: ____
Relationship to Patient: ____
Phone Number(s): ___________________________________ Fax: ____________________________
Address: ____

Recipient/Provider of Confidential Info: ____
Relationship to Patient: ____
Phone Number(s): ___________________________________ Fax: ____________________________
Address: ____

for the purpose of ("continuity of care" if left blank):
____ .

I understand that this is valid until (indefinite if left blank) _______________, that I may withdraw my consent at any time, and that I have a right to receive a copy of this authorization form. I also understand that the information being disclosed pursuant to this authorization may be subject to re-disclosure by the recipient, and may no longer be protected by this privacy rule.

____ _______________
Patient Signature Date

* Compliant with the *Health Insurance Portability and Accountability Act* (HIPAA).