CONSENT FOR RELEASE OF PROFESSIONAL INFORMATION

Information Release in authorized on:

Name:___________________________

D.O.B.:____________

Houston Psychological Associates/ Dr. Stubits is hereby authorized to secure and release psychological, medical, social, educational, and other clinical information regarding the patient named above. **This authorization applies only to the institution/individuals named below:**

Name:____

Address:____

____

Phone:____

Information to be released:____

Name:____

Address:____

____

Phone:____

Information to be released:____

This authorization will be in force while I am a client of Houston Psychological Associates unless revoked by my written notice.

_______________________________________ __________________________

(Signature of Client) (Date)

_______________________________________ __________________________

(Signature of Parent/Guardian) (Date)

Please return via email at: HPA000@AOL.COM or via fax: 713.629.0760