Cristina Lima Therapy
Individual, Couples, and Family
281-770-1779

AUTHORIZATION FOR RELEASE OF INFORMATION

Client's name: Date of Birth

Information to be released:

Intake information	Treatment plans	Psychological testing
Progress notes	Billing/Financial records	Collateral communication
School records	Medical records	Other:

Purpose of Disclosure: At the request of the client

Other (describe):

Person(s) Authorized to Make the Disclosure:

Address and Phone:

Person(s) Authorized to Receive the Disclosure:

Address and Phone:

1. I understand that I may refuse to sign this authorization and that **Dr. Cristina Lima** will not condition treatment, payment, or eligibility for benefits on whether this authorization is signed.
2. I understand that I have the right to revoke this authorization, in writing, at any time by sending notice to **Dr. Cristina Lima**, although I understand that I cannot do anything about information already used or disclosed under this authorization.
3. I understand that unless I revoke this authorization earlier, this authorization will automatically expire 180 days, or according to the relevant state or federal law, from the date this authorization is signed.
4. I understand that information used or disclosed in accordance with this authorization may no longer be protected by federal law, and could be used or re-disclosed by the receiving party.
5. I understand that I will receive a copy of this completed form upon request.

Client Signature 12 yrs. or older Date Parent/Guardian Signature Date

NOTICE TO RECEIVING FACILITY/THERAPIST: You may not re-disclose any of this information unless the person who consented to this disclosure specifically consents to such re-disclosure.