RELEASE OF CONFIDENTIAL INFORMATION AUTHORIZATION

Pursuant to Federal Guidelines concerning my right to confidentiality and state law concerning privileged communications,

I hereby authorize:

Kaleidoscope Behavioral Health
3535 Firewheel Dr., Suite F
Flower Mound, TX 75208
214-499-0396

To release confidential information regarding (client's name) _____

TO:

Organization Name: _____

Individual(s) Name: _____

Address:_____

Phone: _____

PLEASE CHECK ALL THAT APPLY
In the following manner:

_____ to release records, by means of written or verbal dissemination
_____ to request information

The information to be used will be limited to the following (check any that apply):

_____ verbal or written communication between professionals
_____ dates of treatment attendance
_____ diagnosis
_____ test results
_____ session notes
_____ other (specify) _____

This consent will automatically expire one (1) year after the date that appears below.

If this information is released via written documents, copies will be available at Kaleidoscope Counseling office for pick-up (only) in 10 business days from receipt of signed release of confidential information authorization.

The reimbursement for copies of therapeutic records is $10 for the first ten pages, and thirty-three cents for each additional page. These fees are due upon pickup of records and are the responsibility of each receiving party.

I understand that if I am signing as the parent of a minor or as a guardian, the records release may contain references to my family and myself. I understand that I may revoke this consent to release information at any time prior to the stated expiration above. I also understand that any release made between the time I authorized it and then revoked it shall not constitute a breach of my right to confidentiality.

Your relationship to client:

_____Self _____Parent/legal guardian _____Other (describe)_____

_____

Signature Date