



Seek Balance

**Sammie Jones, MA, LPC**  
www.HoustonPsychotherapists.com

**Authorization to Release Information**

I, \_\_\_\_\_ authorize

Sammie Jones, MA, LPC and

\_\_\_\_\_  
(name of person(s) or organization(s) which disclosure is to be made to and/or received from)

to disclose or release **one to the other** the following information from my records:

- \_\_\_\_\_ All Health Care Information  
Initials
- \_\_\_\_\_ Health Care Information or Opinions Relating to any or all of the following treatment(s) and, or conditions:  
Initials
- \_\_\_\_\_ 1) Psychiatric or Mental Health Information  
Initials
- \_\_\_\_\_ 2) Academic and Confidential School Information  
Initials
- \_\_\_\_\_ 3) Testing  
Initials
- \_\_\_\_\_ 4) Other \_\_\_\_\_  
Initials

For the purpose of treatment/management and or supervision or psychological and or medical condition(s), **I hereby waive my right to the privileges of confidentiality as specified above, for a period of one year after termination of treatment, management or supervision unless expressly revoked earlier in writing.**

\_\_\_\_\_  
Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent or Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

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