

Door of Hope Counseling
1201 North Watson Road Suite 142
Arlington, Texas 76006

CONSENT TO RELEASE or OBTAIN INFORMATION

I, _____, hereby give my permission for Cynthia Thompson, M. Ed., LPC to release information pertaining to counseling services received by me or my minor children from. The information may be released to the party listed below:

I also give my permission for the above named agency or person to release information pertaining to me or my minor children to Cynthia Thompson, M. Ed., LPC. The information may be released to the party listed below:

Door of Hope Counseling
Cynthia Thompson, M.ED., LPC-S
1201 N. Watson, suite 142
Arlington, TX 76006

I understand the information to be released may contain medical, psychological, psychiatric, counseling records, social history, or other assessment records which may aid in treatment or program planning.

Records may be released for the following children:

_____ DOB _____
_____ DOB _____

I understand that this authorization may be revoked by me at any time.

_____ Date: _____
Signature of client, parent or legal representative

_____ Date: _____
Witness

Authorization to Release Information has been withdrawn by _____
on _____.