Sonya Sharron, M.S., LPC
9708 S. Padre Island Drive STE A108 Office Cell 361-726-7459
Corpus Christi, TX 78418 FAX:

AUTHORIZATION FOR DISCLOSURE OF MEDICAL/CLINICAL RECORD INFORMATION

RE: Name: _____ DOB: _____
Address: _____

I hereby authorize the release of medical/clinical information regarding treatment beginning (date of initiation of treatment) _____ to be sent to / received from the following party:

_____
_____
_____
_____

Specific records to be released include: (specify)

- ☐ Progress Summary
- ☐ Clinical Progress Notes
- ☐ Treatment Plan(s)
- ☐ Psychosocial History
- ☐ Assessments: (specify): _____
- ☐ Other: _____

Reason for Release of Information:

- ☐ To assist with treatment
- ☐ To assist in funding treatment
- ☐ To assist with educational/occupational placement
- ☐ To assist wit medical treatment planning
- ☐ To assist with discharge/termination of treatment
- ☐ Other: _____

I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization (i.e., information already disclosed) and that in any event this consent expires automatically 180 days after discharge/ termination or 180 days after the date of signature if already discharged/terminated, unless you specify another date, event or condition (specify) _____
_____

I hereby release Sonya Sharron, M.S., LPC from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signatures: _____ _____ _____
Patient signature Date Witness (if needed)

_____ _____ _____
Parent/Guardian Date Relationship