BALANCED COUNSELING
OF
SAN ANTONIO

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Authorization for Release of Information

A $35.00 fee 5 for the first 20 pages and 50 cents for each page thereafter will be charged for release of records. Payment is required at time of request.

Client Name: _____ Date of Birth: ___/___/_____

I authorize _____ from Balanced Counseling of San Antonio, to disclose information and records regarding my treatment and/or behavioral health condition to the following professional person/agency, physician and/or facility;

_____

Provider Address Phone number

Information to be released (Check all that apply):

☐Summary of Treatment ☐Report ☐Other: _____

The authorized purpose(s) for this release are (Check all that apply):

☐Coordination of Care ☐Other: _____

Method of Information Disclosure (Check all that apply):

☐Written ☐Verbal ☐Electronic

I understand that my health information is protected by law. I authorize the release of my confidential health information as indicated above. I understand that my consent is voluntary and I can revoke this permission at any time, except to the extent that it has already been shared based on this authorization.

This consent will automatically expire one (1) year after the date of my signature as it appears below, or on the following earlier date, condition, or event _____.

_____ ___/___/_____
Signature of Client Date

_____ ___/___/_____
Signature of Parent, Guardian, or Authorized Representative, if required Date