



Tiffany Smith Counseling, Inc.

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RELEASE OF INFORMATION CONSENT FORM

I, _____, hereby authorize Tiffany Smith Counseling, Inc. to disclose or receive my protected health information including: psychotherapy notes, progress notes, case notes, billing and scheduling information, assessment and psychological testing reports, physical healthcare treatment records, and psychotherapy treatment and progress.

PLEASE CHECK

____ School: _____
 Contact person _____ Phone# _____
 ____ Medical Doctor: _____
 Address: _____
 _____ Phone# _____
 ____ Previous Therapist: _____
 Address: _____
 _____ Phone# _____
 ____ Insurance Company: _____
 Address: _____
 _____ Phone# _____
 ____ Other: _____
 Address: _____
 _____ Phone# _____

This release shall remain in effect until such time as it is revoked in writing by me.

Signature of Client/Legal Representative

Date of signature

Relationship of Legal Representative

Client's Date of Birth

Expiration Date of Consent

Client's Social Security No.