

Passage Counseling
Kristie Campbell, MEd., LPC-S OF CYPRESS, PLLC

16522 House & Hahl Road, Suite F4 Cypress, Texas 77433
713-515-1702 www.passagecounselingcypress.com

I, _____
(name of client or parent/guardian of client)

Authorize _____ Kristie Campbell, MEd., LPC-S) _____
(name of Therapist)

to exchange _____
(nature of information)

about _____
(name of client)

with _____ at _____
(person to exchange information with)

Contact information: _____

(email, address, or fax information)

for the purpose of _____
(reason for disclosure)

*This authorization shall become effective _____ (date)
and is subject to revocation in writing by the undersigned at any time, except to the
extent that action has already been taken.

*This authorization will terminate one year from effective date unless it is revoked
earlier in writing by the undersigned. Termination Date: _____

*I understand that this information will be used only for the purposes noted above and
will not be disclosed to any other person or agency without my written permission. I
understand I have the right to receive a copy of this authorization upon request.

Signature of Client or Parent/Guardian

Date

Signature of Therapist

Date