



Jacqueline Hernandez, MA, LPC-S
Mental Health Therapist

RELEASE OF INFORMATION AUTHORIZATION

I hereby authorize **Revelation Counseling Services** to:

- Release/Disclose records of the health information regarding the patient below.
- Obtain/Request records of the health information regarding the patient below.

CLIENT NAME

DATE OF BIRTH

NAME OF INDIVIDUAL/SCHOOL/FACILITY/ORGANIZATION/COMPANY (to whom information will be released)

ADDRESS

PHONE

FAX

I consent to the following disclosures:

- Academic Testing Results
- Behavior Plan
- Medical Reports
- Progress Notes/Treatment Plans
- Psychological/Neuropsychological Testing
- Other _____

The information above will be used for the following purposes:

- Planning appropriate treatment or program
- Continuing appropriate treatment or program
- Case review
- Other _____

I understand that I may revoke this consent at any time by providing written notice, and after one year this consent automatically expires. I have been informed what information will be provided/obtained, its purpose, and who will receive the information.

Signature of Client or Parent/Legal Guardian (if Minor)

Date

Printed Name of Parent/Guardian (if Client is a minor)