Kirkland
CLINICAL ASSOCIATES

Kirkland Clinical Associates LLC/Dan Kirkland MS, LPC-S

Authorization for Release of Records or Information

I, _____ _____ hereby give permission to
Name Social or B-day

Kirkland Clinical Associates LLC/ Dan Kirkland MS, LPC-S to disclose to and converse with _____ about:

____ My entire record; or

____ specified information limited to _____.

I may revoke this consent at any time by writing to the holder of the information except to the extent that action has been taken in reliance upon it. If I do not revoke it, this consent will expire in one year after I have terminated treatment. I understand that the specific information to be disclosed may include history of drug and alcohol abuse or mental health treatment, information concerning communicable diseases such as HIV and AIDS, treatment progress, and any other such related, but will not include psychotherapy notes. I understand that I may withdraw or revoke my permission at any time by notifying Kirkland Clinical Associates LLC/Dan Kirkland MS, LPC-S in writing.

My treatment will not be based on the completion of this authorization form. The information to be released by this authorization may be re-released by the person or organization that receives it and may no longer be protected by Federal or Texas privacy regulations.

I release Kirkland Clinical Associates/Dan Kirkland MS, LPC-S from legal responsibility or liability for the disclosure of the records as authorized on this form. I understand that this authorization is voluntary and that I may refuse to sign it. I will be provided a copy of this signed authorization, if requested. A photocopy of this authorization is as valid as the original.

_____ _____ _____
Signature of Patient Date Signature of parent or representative