

## Parental Release of Information Form

### RELEASE OF INFORMATION AUTHORIZATION

I hereby authorize Tamara Allen Bush, LPC-S, NCC, CSAT  
(name of party who holds your information)

Tamara Allen Bush LPC-S, NCC, CSAT  
(address of party who holds your information)  
P.O. Box 885, Keller, TX 76244 Phone : 817-713-7223  
tamaraallenlpc@gmail.com

(phone number, email address, fax number)  
to release the following specified information regarding the treatment of:

_____	_____ (patient(s) name(s)).
Date of Birth: _____	Date of Birth: _____
_____	_____ (patient(s) name(s)).
Date of Birth: _____	Date of Birth: _____

Release Information to BOTH parents:

Custodial Parent : \_\_\_\_\_  
\_\_\_\_\_  
(name of person or agency and mailing address)

Non-Custodial Parent: \_\_\_\_\_  
\_\_\_\_\_  
(name of person or agency and mailing address)

I request the following information be released:

\_\_\_\_\_ Office Notes    \_\_\_\_\_ Verbal Consult    \_\_\_\_\_ Entire Record    \_\_\_\_\_ Other :

I understand these records can include drug/alcohol/mental health-related information. A photocopy of this authorization should be considered as valid a the original. This consent is subject to revocation by the patient, shall expire one year from the date below.

Custodial Parent Name: \_\_\_\_\_ Date: \_\_\_\_\_

Non-Custodial Parent Name: \_\_\_\_\_ Date: \_\_\_\_\_