Tamara Allen Bush LLC
Tamara Allen Bush, LPC-S, CSAT-S, CMAT, ICGC-1
P.O. Box 885, Keller, TX 76244
817-713-7223 tamaraallenlpc.com

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_ RELEASE OF INFORMATION AUTHORIZATION

I hereby authorize Tamara Allen Bush LPC-S, CSAT-S, CMAT, ICGC-1 (name of party who holds your info) P.O. Box 885, Keller, TX 76244 817-713-7223 tamaraallenlpc@gmail.com (address, phone & email)
To release the following specified information regarding the treatment of:

_____ (Client Name)
Date of Birth:_____

Release Information to:

_____ (Name of Provider, Person, Facility)

_____ (Organization)
_____(Address)
_____Phone _____(Email)

I request the following information be released:
_____Office Notes _____ Entire Record _____Verbal Consult _____
Other :_____

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

Client Name: _____ Date: _____

Client Name: _____ Date: _____