Alicia Muñoz, LPC
Individual and Couple Psychotherapy
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Consent Form

Authorization to Release Confidential Records /Information

I hereby authorize Alicia Muñoz, LPC to release information to/receive information from ______________________

____ (person and/or facility) at (address/phone) __________

____

about client ____ for the purposes of ______________

____.

These records concern the time period between________________________ and ______________________.

I have had explained to me and fully understand this request/authorization to release records and information, including the nature of the records, their contents, and the likely consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may take back this consent at any time within 90 days, except to the extent that action based on this consent has already been taken. This consent will expire automatically after 90 days from the date on which it is signed, or upon fulfillment of the purposes stated above. I understand that if the person or organization that receives this information is not a health care provider or health insurer the information may no longer be protected by federal privacy regulations.

Client Signature ______________________ / ________________________ **Date** ______________
SIGN PRINT