Christina Taylor, LPC, PLLC
802 W. Center Street
Kyle, TX 78640
512-649-3210
www.ChristinaTaylorLPC.com

AUTHORIZATION FOR RELEASE OF INFORMATION

I, ____, give full authorization to Christina Taylor, LPC, PLLC to provide/exchange information regarding my mental health information to/with:

____
Name

____
Phone Number

____
Street Address

____
City, State, Zip Code

for the purpose(s) of ____

____.

I understand that authorization shall remain valid from the date of my signature below and ending on

________________.

I have been informed that I may revoke this authorization by written communication to Christina Taylor at any time.

I certify that this form has been fully explained to me and that I understand its contents.

____ _________________________
Signature of Client Date of Authorization