Karen Stone, MS, LMFT, LCDC

860 Hebron Parkway, Suite 803
Lewisville, TX 75057
Phone: 214-454-9672
Fax: 972-459-7263

CONSENT TO RELEASE INFORMATION FORM

I, _____, hereby authorize Karen Stone, MS, LMFT, LCDC to disclose
(client or legal representative)

records and/or information concerning services rendered to:

_____ _____
Client Name Client's Date of Birth

This information is to be released to:

_____ _____
Name and/or Agency Phone number

_____ _____
Mailing Address Fax number

_____
City State Zip

Records are to be forwarded to the ATTENTION OF: _____

The disclosure of information authorized is made for the following purpose:

_____

Such disclosure shall be limited to the following specific types of information:

_____

The above authorization is to be in effect until such time as I revoke it in writing or shall terminate

on _____ without express written revocation.
(date/event/condition)

SIGNED:_____ _____
(Client/Legal Representative) (Date of Signature)

_____
(Relationship of Legal Representative)

SIGNED:_____ _____
(Client/Legal Representative) (Date of Signature)

_____
(Relationship of Legal Representative)