Tiffany Stanley Therapy
2720 Bee Cave Road, Suite 207
Austin, Texas 78759
Office: 512-585-4098
drtiffanystanley@gmail.com

Authorization to Receive or Release Information

Please be advised that mental health records constitute privileged information that is protected by the laws of the State of Texas and they contain information that is protected under the Federal Confidentially Regulations. These records cannot be disclosed without written consent unless otherwise provided for/in Federal regulations. Authorizing the release of information contained in mental health records constitutes waiver of a privilege. You may revoke this consent through written notice but will not apply to action that has been taken prior to receipt of the revocation. This consent is valid for 180 days from the signature date below, unless otherwise specified.

I, ____ hereby authorize and request Tiffany Stanley, PHD, MA, NCC, LPC-S, to release *and* receive all pertinent, confidential and professional information pertaining to myself, when applicable to:

Name: ____

Address: ____

Phone Number: ____

Fax number: ____

Email: ____

In consideration of this consent, I hereby release the above parties from any legal liability resulting from the release of this information.

***Please note this authorization revokes and replaces any previous authorization to receive and release information.

Signature: ____

Date: ____