Neurotherapy
Center of Houston
A BRAIN FITNESS CLINIC

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AUTHORIZATION TO RELEASE INFORMATION

Client's Name: ______________________ Date of Birth: ______________________

Previous Name: ______________________ Social Security #: ______________________

I request and authorize ____ to release information of the client named above to:

Name: ____

Address: ____

City: ______________________ State: __________ Zip Code: __________

This request and authorization applies to:

☐Information relating to the following treatment, condition, or dates: ______________________

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☐ All mental health information

☐ Other: ____

Client Signature: ______________________ Date Signed: ______________________