Iristela Rodriguez, MA, LMFT, LPC
4502 Riverstone Blvd. Suite 902
Missouri City, TX 77459
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Brightertomorrows01@gmail.com

Consent for Treatment Authorization to Release Medical Information

I hereby consent to testing, treatment, and other diagnostic and therapeutic services rendered to me on behalf of Iristela Rodriguez, LMFT.

I further authorize release of my medical information to the insurance companies or parties that are or may be liable for all or part of the charges incurred by me with Iristela Rodriguez, LMFT, such diagnostic and therapeutic procedures which may include sensitive information including drug/alcohol abuse, and/or psychiatric conditions.

This authorization shall be valid only for the period of time in treatment with Iristela Rodriguez, LMFT.

Patient's Signature:_____ Date:_____

Print Patient's Name:_____

Parent/Guardian's Signature:_____ Date:_____

Assignment of Benefits

I hereby authorize payment directly to Iristela Rodriguez, LMFT, insurance benefits otherwise payable to me. I understand I am financially responsible to Iristela Rodriguez, LMFT for charges not covered by this authorization.

Patient's Signature:_____Date:_____

Print Patient's Name _____

Parent/Guardian's Signature:_____ Date:_____

Witness:_____Date:_____