CCD Counseling P.A.
Denton Lewisville Farmers Branch
Administration: 1512 Scripture Street, Denton, Texas 76201
(940) 382-5328 www.ccdcounseling.com www.facebook/ccdcounseling

Authorization to Disclose Information

I, _____ am completing this form to allow the use and sharing of information about myself, and/or the following minor children, for whom I can legally grant consent (for each person listed, write your legal relationship which entitles you to sign): _____
Names and Relationships or "N/A"

_____

1. Parties authorized
I authorize CCD Counseling P.A. (CCD) and/or

_____

_____

_____

to release or disclose records and/or information concerning counseling, treatment or other services received by myself and/or minor children.

I am authorizing for information:
- ☐ to be disclosed by CCD to the above agency/individual, only.
- ☐ to be disclosed by the above agency/individual to CCD, only.
- ☐ to be exchanged between CCD and the above agency/individual.

2. Purpose
The purpose of this disclosure is
- ☐ _____
- ☐ at the request of the individual

3. Description of Information
The information to be disclosed is: (check one):
- ☐ The entire record.
- ☐ The minimum that CCD believes is required to accomplish the stated purpose.
- ☐ Any information that meets these specific criteria: _____
_____.

4. Expiration Date
I understand and agree that this Authorization will be valid and in effect, unless I revoke (cancel it), until: (check one):
- ☐ 3 months following the date of signature
- ☐ 3 months following my last service at CCD
- ☐ 3 months following the resolution of the legal action related to my services
- ☐ _____

I understand that after that date or event, no more of this information can be disclosed to the person or organization unless I sign a new Authorization.

Initials _____

Authorization to Disclose Protected Health Information (continued)

5. Right to Revoke

I understand that I can cancel this Authorization at any time by sending a letter to the Privacy Officer of the organization(s) listed above. If I do this, it will prevent any disclosures not required by law after the date it is received, but cannot change the fact that some information was sent or shared before that date. See Notice of Privacy Practices.

6. Not Required for Treatment

I understand that an authorization is not required if the information is to be used for Treatment, Payment, or Health Care Operations (TPO). I understand that if this disclosure was already permitted under my consent, that CCD's request for this form was a sign of their respect for my rights and does not in any way invalidate my original consent. I also understand that if the information is Health Care information and is not required for TPO, that I do not have to sign the authorization, and my refusal to sign will not affect my ability to obtain treatment from CCD.

6. Re-disclosure

I understand that if the person or organization that receives my information is not a health care provider or health insurer; or if my records are not protected health information, the information may no longer be protected by privacy regulations. I also understand that CCD cannot control how information it has disclosed is used by other parties.

Notice Regarding non-PHI services. :

I understand that some services available at CCD do not involve Protected Health Information. An example is an educational workshop, or some court related services. Other services do not create PHI, but may contain PHI created by someone else. An example of this is a court ordered social study. I understand that I may have different rights related to those records. For example, if one is receiving services related to a court case, the right to refuse to sign and the related consequence is determined by the court.

I acknowledge and understand I am waiving my right to confidentiality with respect to the information I am asking to be disclosed by this Authorization and hereby release CCD Counseling P.A., including my therapist and other staff from any and all liability arising from this disclosure.

If I have listed minor children on this release, I also attest that I am the parent, legal guardian, or otherwise have the legal right to consent for the medical treatment of the above minor. I am not required in a divorce decree or otherwise to have the consent of any other prior to this minor receiving such services.

Everything that was not clear to me has been explained and I believe I now understand all of it. I will receive a copy of this form after I sign it.

Printed Name: _____

Signature: _____ _____

Date

Printed Name: _____

Signature: _____ _____

Date