Lewisville Counseling Services Authorization to Release Information

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of Protected Health Information (PHI) when applicable. Covered entities as that term is defined by HIPAA and Texas Health and Safety Code 181.001 must obtain a signed authorization from the individual to electronically or otherwise disclose that individual's protected health information.

To: _____

_____

_____

Client(s): _____ DOB_____

_____ DOB_____

_____ DOB_____

Purpose: _____

HIPAA Statement: I understand information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer protected. I understand treatment or payment cannot be conditioned on signing this authorization. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code 181.154(c) and/or CFR 164.502(a)(1).

The undersigned hereby authorizes and requests that the above named person or organization:

☐ Release and/or disclose information to Lewisville Counseling Services
☐ Receive information from Lewisville Counseling Services
☐ Exchange information between Lewisville Counseling Services

about the above client(s) in the following areas:

☐ medical ☐ discharge summary ☐ CPS records ☐ mental health records _____ **Initials required**
☐ dental ☐ admissions summary ☐ psychiatric _____**Initials required**
☐ school ☐ social history ☐ psychological evaluations _____ **Initials required**
☐ day care ☐ probation/parole ☐ police records ☐ other: _____
☐ In accordance with federal Regulations 42 CFR part 2, consent is also given to release any alcohol/drug abuse treatment records under the conditions above.
☐ Any and all AIDS/HIV related conditions and testing _____ **Initials required**
☐ Genetic Information (including Genetic Test Results)_____**Initials required**

The client signing this form will be responsible for any fees incurred from this request.

This authorization may be revoked in writing to LCS at any time except to the extent that the information has been received and incorporated into any client files or reports. This release is effective until 3 months following my last date of service, or 3 months following the resolution of any legal action related to my services. A photocopy, email or fax of this authorization is as valid as the original, and dates of service include the entire lifetime(s) of the above named person(s).

_____

Signature Printed Name Date

_____

Signature Printed Name Date