Hollie Wilson Counseling
2000 Highland Village Road, Suite C Highland Village, TX 75077
Phone: 205-238-1207
www.holliewilsoncounseling.com

CLIENT AUTHORIZATION FOR THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

This form allows the exchange of information between Hollie Wilson Counseling and the person(s) to whom you grant consent below. The goal of such information exchange is to coordinate your care as best as possible. The information exchanged may include psychosocial evaluation, assessment, treatment plan, medical information, laboratory records, billing & scheduling information, psychotherapy notes, progress notes, case notes, and psychotherapy and progress.

Client Name: _____ DOB: _____

I authorize Hollie Wilson Counseling to disclose to and/or obtain from records of my/my child's health information:

Individual, Facility, Organization _____

Address _____ (Street, City, State, Zip) Phone Number _____

Information to be released includes:

_____ Assessment/Psychosocial Evaluation _____ Current Treatment Update
_____ Educational Information
_____ Progress in Treatment _____ Diagnosis
_____ Treatment Plan or Summary _____ Discharge/Transfer Summary _____ Demographic Information
_____ Other _____ _____ Treatment Recommendations

The purpose of this disclosure of information is _____

I understand that I have the right to revoke this authorization at any time by providing written notification. I further understand that a revocation of authorization is not effective to the extent that action has been taken in reliance on the authorization. This authorization expires on the following date: _____ or as otherwise indicated: _____.

I further understand that the provision of health care treatment to me cannot be conditioned upon my agreement to sign an authorization for the disclosure or use of my health information for purposes other than for treatment, payment, and healthcare operations.

I understand that there is the potential that protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is stricter than HIPAA and provides additional privacy protections.

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Client/Guardian Signature: _____ Date: _____

Printed Name: _____ Relationship to Client: _____

Signature of Therapist: _____ Date: _____