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

HIPAA AUTHORIZATION FORM

I, (name) _____, whose date of birth is _____, authorize Hollie Wilson to disclose to and/or obtain from _____ the following information regarding (client name)_____:

Description of Information to be Disclosed
(Patient/Client should initial each item to be disclosed.)

____ Assessment ____ Testing Information
____ Diagnosis ____ Educational Information
____ Psychosocial Evaluation ____ Presence/Participation in Treatment ____ Psychological Evaluation ____ Continuing Care Plan
____ Treatment Plan or Summary ____ Progress in Treatment
____ Current Treatment Update ____ Other _____ **Purpose**

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment, and, when appropriate, coordinate treatment services. If other purpose, please specify: _____

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Hollie Wilson Counseling at the above address. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration

Unless sooner revoked, this authorization expires upon termination of treatment or as otherwise indicated:
_____

Conditions

I further understand that Hollie Wilson, LCSW-S will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences:
_____
_____

Form of Disclosure

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.

Redisclosure

I understand that there is the potential that the protected health information (PHI) 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 more strict than HIPAA and provides additional privacy protections. Other types of information may be re-disclosed by the recipient of the information in the following circumstances:

_____

_____

I will be given a copy of this authorization for my records.

_____

Signature of Client Date

_____

Signature of Parent, Guardian, or Personal Representative Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual. Attach appropriate document (power of attorney, temporary orders, healthcare surrogate, etc.)

_____

_____

_____ Check here if client refuses to sign authorization.

_____

Signature of Therapist Date