

## **Counseling Center of Montgomery County PLLC**

## HIPAA AUTHORIZATION FORM

I,	, whose date of birth is	authorize Rebecca Smith, MA, LPC-S
to disclose to and/or obtain from		, whose
address is		
phone number:	fax number:	the following
information in regard to:		
<u>Description of Information to be Di</u> (Client should initial each item to be d		
AssessmentDiagnosis	Educa	ng Information ational Information
Psychosocial Evaluation Psychological Evaluation Treatment Plan or Summary Current Treatment Update	Conti	
HIV/AIDS Test Results/TreatnDrug, Alcohol or Substance Ab  Purpose The purpose of this disclosure of inforelevant to treatment and when appre	use Records (Including those covere rmation is to improve assessment a	nd treatment planning, share information
Revocation  I understand that I have a right to rev to Rebecca Smith, MA, LPC-S at the ab authorization by entities that had per Effective Time Period/Expiration	oove address. I understand that prior	
This authorization is valid until the eareaches the age of maturity; permissis specific date:	on is revoked in writing; 120 days fr	of death of the individual; the individual rom the date of signing; or the following
wonuiDay	Year	

Coı	ndi	tio	ns

I further understand that Rebecca Smith, MA, LPC-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: could potentially impact your therapeutic process and
treatment plan.

other		

## Form of Disclosure

Unless you have specifically requested in writing that the disclosure be made in a certain format, I reserve the right to disclose information as permitted by this authorization in any manner that I 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 that is disclosed pursuant to this authorization may be redisclosed by the recipient and that federal or state privacy laws may no longer protect the protected health information.

**Signature Authorization:** I have read this form and agree to the uses and disclosures of the information as described. 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 and Safety Code 181.154(c) and/or 45 C.F.R. 164.502(a)(1). Upon request, I will be given a copy of this authorization for my records.

Signature of Client	Printed Name	Date
Signature of Parent(s), Guardian or Legally A	Authorized Representative Printed Name	e Date
If you are signing as representative, speci	fy relationship to client:	
Parent(s) of MinorGuar	rdianOther	<del></del>
release of information related to certain t alcohol or substance abuse and mental he		, 3
Signature of <b>Minor</b> Client	Printed Name	Date
Refusal to Sign Authorization  Initial here if client refuses to sign au	uthorization	
Rebecca Smith, MA, LPC-S		Date