OSANA
MENTAL HEALTHCARE & COUNSELING SERVICES

DR. LETTICA JOHNSON-HIGHSMITH, DNP, APRN, PMHNP-BC, FNP-C
1601 MAIN STREET STE. 211 RICHMOND, TX 77469
OFFICE: 832.847.4836 / FAX: 832.847.4852
WWW.OSANAMHCS.COM

AUTHORIZATION FOR RELEASE/REQUEST OF INFORMATION/RECORDS

I,_____ DOB:_____

hereby give my permission to Osana Mental Healthcare & Counseling Services, to release or request from a third-party information contained in my medical record. I understand that my medical record may contain information concerning my psychiatric, psychological, drug or alcohol abuse, sexual abuse treatment, HIV/Acquired Immune Deficiency Syndrome (AIDS) and/or related conditions, and that under law these records are classified as privileged and confidential and cannot be released to me or those designated by me or my legal guardian without an expressed and informed consent. In addition, I understand that those records will not be released to entities other than those designated by myself or my personal representative or otherwise provided in federal law.

This information will be released/requested upon request to the following:

To/From:

_____

FIRST AND LAST NAME, PHONE, AND ADDRESS OF PERSON(S)

THE TYPE OF INFORMATION TO BE DISCLOSED/REQUESTED IS AS FOLLOWS: (PLEASE PLACE A CHECK MARK TO IDENTIFY)

To Be Released	To Be Requested
FROM OSANA MENTAL HEALTHCARE & COUNSELING SERVICES	FROM THIRD- PARTIES
____ Treatment Plans	____ Treatment Plans
____ Process Notes	____ Process Notes
____ Health/Medical Records (if applicable)	____ Health/Medical/Academic Records
____ Letter(s) of Progress	____ Psychological/Psychiatric Evaluations/Assessments
____ Bio Psychosocial Evaluation/Assessment (if applicable)	____ Court Documents
____ Verbal Communication	____ Verbal Communication
____ Other (Specify): _____	____ Other (Specify): _____

** IN THE CASE OF NOTES DOCUMENTING OR ANALYZING THE CONTENTS OF CONVERSATION DURING A PRIVATE COUNSELING SESSION ("PROGRESS NOTES"), SUCH RECORDS MAY BE PROTECTED FROM DISCLOSURE UNDER THE HIPAA PRIVACY RULE).**

_____(initial) I understand that I have the right to withdraw my authorization at any time except to the extent that action has already been taken pursuant to the authorization. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Osana Mental Healthcare & Counseling Services.

_____(initial) I understand that authorizing the disclosure of this health information is voluntary, I can refuse to sign, and Osana Mental Healthcare & Counseling Services will not base my treatment or payment whether or not I provide authorization for the requested use or disclosure. I understand that I may inspect or copy the information to be disclosed, as provided in CFR164.524 (with reasonable charge).

_____(initial) I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of the information and is no longer protected by federal confidentiality laws or Osana Mental Healthcare & Counseling Services. Osana Mental Healthcare & Counseling Services will not be held liable for information disclosed to another party per the client's request.

_____(initial) I understand that Osana Mental Healthcare & Counseling Services will release only the minimum amount of information necessary to fulfill a request.

THIS AUTHORIZATION SHALL EXPIRE WHEN THE CLIENT IS DISCHARGED FROM THE CURRENT EPISODE OF CARE (TREATMENT HAS BEEN COMPLETED, THE CLIENT REJECTS/DECLINES/DROPS OUT OF TREATMENT, IS REFERRED ELSEWHERE, MOVES, OR IN THE CASE OF THE CLIENT'S DEATH.) THIS AGREEMENT IS SUBJECT TO REVOCATION IN WRITING AT ANY TIME.

Release:	Request:
FROM OSANA MENTAL HEALTHCARE & COUNSELING SERVICES	FROM THIRD- PARTIES
_____	_____
Signature Client/Next of Kin/Guardian Date	Signature Client/Next of Kin/Guardian Date
_____	_____
Clinician Signature/Credentials Date	Clinician Signature/Credentials Date