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**AUTHORIZATION TO EXCHANGE/RELEASE PROTECTED HEALTH INFORMATION**

Pursuant to Federal Guidelines concerning my right to confidentiality and state law concerning privileged communications.

**I hereby authorize**:

 Summit Counseling of North Texas, PLLC

 6020 Wayne Court

 Flower Mound, TX 75028

 972-822-8338

**To communicate with or release confidential information to:**

Name:

 Phone:

PLEASE CHECK ALL THAT APPLY

**In the following manner**:

\_\_\_\_\_ To release records, by means of written or verbal communication

\_\_\_\_\_ To request information

**The information to be used will be limited to the following (check all that apply):**

\_\_\_\_\_ Verbal or written communication between professionals

\_\_\_\_\_ Dates of treatment attendance

\_\_\_\_\_ Diagnosis

\_\_\_\_\_ Test results

\_\_\_\_\_ Session notes

\_\_\_\_\_ Other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This consent will automatically expire one year after the date of my signature as it appears below.

The reimbursement for copies of provider records is forty cents per page plus postage if they require mailing.

I understand that:

\*I understand that if I am signing as the parent of a minor or as a guardian, the records released may contain references to myself and my family.

\*I may revoke this consent to release information at any time prior to the stated expiration above.

\*Any release made between the time I authorized it and then revoked it shall not constitute a breach of my right to confidentiality.

\*Even if I revoke this authorization, the use or disclosure of my protected health information could possibly still be compelled by Court Order under state law as indicated in the copy of the Privacy Notice of Summit Counseling of North Texas, PLLC, which I have received and reviewed.

Client Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_