Austin Wellness, PLLC
www.austin-wellness.com
10010 Anderson Mill Rd.
Austin Texas 78750
512-257-0050

Client Name: ___________________________________ Today's Date: __________________
Date of Birth: ___________________ Social Security #: ________________________________

AUTHORIZATION FOR THE USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I authorize the use and/or disclosure of my protected health information by Austin-Wellness, PLLC and all employees as described below:

1. My authorization applies only to the information checked below. Only this information may be used and/or disclosed pursuant to this authorization (check all that apply):
   a. _X_ Confirmation that I have contacted the office of Therapist.
   b. _X_ Number of times I have contacted the office of Therapist.
   c. ____Information discussed regarding my job performance.
   d. ____Recommendations for treatment and whether I followed that treatment.
   e. ____Summary of assessment done by the Therapist.
   f. ____Other ____.

2. I authorize the following persons (or class of persons) to make the authorized use and/or disclosure of my protected health information:
   a. _X_ Therapist.
   b. _X_ Therapist's Employees.

3. I authorize the following persons (or class of persons) to receive my protected health information (i.e. my spouse, employer, etc.): ____.

4. I understand that, if my protected health information is disclosed to someone who is not required to comply with state and federal privacy protection laws and regulations, such information my be re-disclosed and would no longer be protected.

5. I understand that I have a right to revoke this authorization at any time. My revocation must be in writing. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization. Any request to revoke this authorization must be sent in writing to the Office of Austin-Wellness, PLLC @ 10010 Anderson Mill Road, Austin, Texas, 78750.

6. This authorization expires one month after the end of my treatment by Therapist.

7. I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from Therapist, nor will it affect my eligibility for benefits.

8. I understand that I have a right to inspect and copy my own protected health information to be used or disclosed, (in accordance with state and laws and regulations and the requirements of the federal privacy protection regulations found under 45 C.F.R. 164.524), except when Therapist has the legal right to refuse such access.

I certify that I have received a copy of the authorization. Client Signature _________________________________
Signature of parent or guardian if client is a minor child ____