Austin Wellness, PLLC
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CONSENT AND AUTHORIZATION OF DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of Protected Health Information (PHI). Covered entities as that term is defined by HIPAA and Texas Health & Safety Code § 181.001 must obtain a signed authorization from the individual or the individual's legally authorized representative to disclose that individual's PHI. Authorization is not required for disclosures related to treatment, payment, health care operations, performing an insurance or health maintenance organization function, or as may be otherwise authorized by law. Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws. **No disclosure can occur unless this form is completely filled out.**

Third Party Information (*provide all information*)
Name: _____
Organization: _____
Address: _____City:_____
State: ____ Zip: _____ Phone: _____
Email: _____

Therapist name:

_____

Client Information (*provide all information*)
Name: _____
Last First Middle
Date of Birth: _____*(mm/dd/yyyy)*
Address: _____City:_____
State: ____ Zip: _____ Phone: _____
Email:_____
When therapy involves more than one person (e.g., couple, family, group), a separately signed form is required from each person before the release of any information is permitted.

Reason for disclosure
___ Treatment/Continuing Care ___ Billing or Claims
___ Insurance ___ Legal Purposes
___ Disability Determination ___ School or Employment
___ Other _____

Information to disclose to third party
___ Summary of progress ___ Billing information
___ Mental Health Records, no therapy notes
___ Other _____

Information to disclose to therapist
___ Summary of progress ___ Billing information
___ Mental Health Records, no therapy notes
___ Other _____

Effective Time Period This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): _____ (mm/dd/yyyy)
Right To Revoke I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named to receive the PHI. I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.
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 other covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.506(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws. I also authorize the transmittal of this Treatment Disclosure Authorization from/to the disclosing or receiving party by fax or e-mail, understanding that electronic communication is not secure and may be seen by a third party.

Signature of a minor is required for release of Mental Health PHI (Tex. Fam. Code § 32.003)

Client Name (Print): _____ Signature: _____ Date: _____

Parent/Guardian Name (Print): _____ Signature: _____ Date:_____

Client's Legally Authorized Representative

Representative's relationship to client: ___ Parent of minor ___ Guardian ___ Other _____
Signature of Therapist: _____ Date: _____