Authorization for Release of Protected Health Information

Therapy San Marcos

102 Whitetail Dr. Suite 100

San Marcos, Texas 78666

903-461-1837

CLIENT INFORMATION

Name: _____

Date of Birth: _____

Address: _____

Phone Number: _____

AUTHORIZATION DETAILS

I hereby authorize Therapy San Marcos to:

☐ Release my protected health information to

☐ Obtain my protected health information from

RECIPIENT/SENDER INFORMATION

Name/Organization: _____

Address: _____

Phone: _____ Fax: _____

Email (if applicable): _____

INFORMATION TO BE RELEASED

The following information may be released (check all that apply):

☐ Entire mental health record

☐ Progress notes

☐ Treatment plans

☐ Diagnosis and assessment reports

☐ Billing records

☐ Other (specify): _____

DATE RANGE OF RECORDS

Records from: _____ to _____ (leave blank for all records).

PURPOSE OF RELEASE

The purpose of this disclosure is (check all that apply):

☐ Continuation of care

☐ Legal proceedings

☐ Insurance purposes

☐ Personal use

☐ Other (specify): _____

EXPIRATION

This authorization expires on (date): _____ or upon the following event: _____ (if no date/event specified, expires one year from the date of signature).

CLIENT RIGHTS AND ACKNOWLEDGMENTS

- I understand that I may revoke this authorization at any time in writing, except to the extent that action has already been taken in reliance on it. Revocation must be sent to Therapy San Marcos at the address above.

- I understand that the information released may be subject to re-disclosure by the recipient and may no longer be protected by federal or Texas privacy laws.

- I understand that my treatment, payment, or eligibility for benefits will not be conditioned on signing this authorization, except as permitted by law.

- I understand that Texas law (e.g., Texas Health and Safety Code §611.004) and HIPAA (45 CFR Part 164) protect the confidentiality of my mental health records, and this release complies with those regulations.

- I have the right to receive a copy of this authorization.

SIGNATURE

Client Signature: _____ Date: _____

WITNESS (if required)

Name: _____

Signature: _____ Date: _____