DEBRA ALLDREDGE, M.A., A.T.R.-BC, L.P.C-AT.,L.M.F.T.
Registered Art Psychotherapist Board Certified
Licensed Professional Counselor
Licensed Marriage & Family Therapist

Authorization for Release of Information

I, authorize Debra Alldredge, MA,ATR-BC,LPC-AT,LMFT *(Provider of Services)* to release Clinical information and Assessment about *(Client)* _____ to Clinical staff of *(Enter Name, Address & Phone for Managed Care Company or EAP)* _____

_____

_____

_____ and/ or *(Enter Name, Address & Phone for Primary Care Physician (PCP)*

_____

_____

for the purpose of Clinical Impressions, treatment planning, discharge and aftercare. This consent is valid until _____(minimum 6 months)

I , the undersigned understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it and that in any event this consent shall expire 6 months from the date of signature, unless another date is specified.

To the Party Receiving this Information: This information has been disclosed to you from records which are protected by federal and state laws regarding confidentiality. Such laws prohibit you from making any further disclosure of this information without specific written consent of the person to whom it pertains, or as otherwise permitted by law. a general authorization for the release of medical or other information is not sufficient for this purpose.

I have read and understand the above information:

_____ I give my consent for releasing the information to my primary care physician.

_____ I do not give my consent for releasing the information to my primary care physician.

Client's Birthdate:_____ Client's Social Security#_____

_____ Date: _____

Client signature and information

_____ Date: _____

Parent or Guardian signature

_____ Date: _____

Witness signature

214 Brooks St. (Spur 58) - Sugar Land, TX 77478 - (281)980-0083 - Fax (281)565-6150

DEBRA ALLDREDGE. M.A. A.T.R.-BC. L.P.C.-AT. LM.F.T.
Registered Art Psychotherapist – Board Certified Licensed Professional Counselor Licensed Marriage & Family Therapist

Authorization for Release of Information

I, _____ *[Name of Patient/Client]*, whose Date of Birth is _____,

authorize Debra Alldredge, MA, ATR-BC, LPC-AT, LMFT. (Provider of Services) to disclose to and/or obtain from:

_____ the following information:
[Insert Name of Person or Title of Person or Organization]

Description of Information to be Disclosed **(Patient/Client should initial each item to be disclosed)**

____Diagnosis	_____ Psychosocial Evaluation	_____Psychological Evaluation
____Psychiatric Evaluation	_____ Treatment Plan or Summary	_____ Current Treatment Update
____Medication Management Information	_____ Presence/Participation in Treatment	_____Progress in Treatment
____ Nursing/Medical Information	_____ Demographic Information	_____ Assessment
____ Educational Information	_____ Discharge/Transfer Summary	_____ Continuing Care Plan
____ Psychotherapy Notes* (*cannot be combined with any other disclosure)		_____Other _____

Purpose: The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services. If the purpose is other than specified, please explain:

_____

Revocation : I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Debra Alldredge, MA, ATR-BC, LPC-AT, LMFT. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration : Unless sooner revoked, this authorization is valid until: (date, minimum of 6 months or use "as Needed")
_____.

Conditions : I further understand that Debra Alldredge, MA, ATR-BC, LPC-AT, LMFT will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences:

_____

Form of Disclosure : Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Redisclosure : I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections.

I will be offered a copy of this authorization for my records.

_____
Signature of Patient/Client Date

_____
Signature of Parent, Guardian or Personal Representative Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.).

214 Brooks Street Sugar Land. TX 77478 Phone: 281 980 0083 Fax: 281 565 6150