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**FORM 6: Authorization to Disclose Mental Health Information**

This form allows you to give me permission to disclose to and obtain information from those entities which assist in assessment and your treatment planning. Please complete a separate form for each entity [office, agency, physician, dietitian, spouse, parent, grandparent etc.] If listing an organization [such as a school], you may specify the names of those persons you wish to be included in this release. You may receive a copy of this authorization for your records upon your request.

Your [or child's] Name [print] \_\_\_\_\_ Birthday \_\_\_\_\_

Parent/Guardian Name [print] \_\_\_\_\_ Relationship \_\_\_\_\_  
[if client is under age 18]

I authorize Sharon L Ward, MS, LPC, NCC to share information with and/or obtain information from:

Provider/Other  
Name: \_\_\_\_\_

Circle one: psychiatrist/counselor/parent/spouse/dietitian/child/ physician/agency/school/lawyer/grandparent/insurance/hospital  
other \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_ email \_\_\_\_\_

Name of other personnel at this agency, hospital, school [etc] that may receive or disclose information \_\_\_\_\_

Description of Information to be Disclosed - please **initial**

- |  |  |
|--|--|
| <input type="checkbox"/> Assessment and Evaluation [testing, questionnaires, clinical observation] | <input type="checkbox"/> Discharge/Transfer Summary  |
| <input type="checkbox"/> Billing/payment information   | <input type="checkbox"/> Scheduling of appointments  |
| <input type="checkbox"/> Diagnosis   | <input type="checkbox"/> Alcohol/Drug history or use   |
| <input type="checkbox"/> Treatment Plan/Update/Summary   | <input type="checkbox"/> Information needed for couples or marital therapy   |
| <input type="checkbox"/> Medication Management Information   | <input type="checkbox"/> Information needed for treatment of child   |
| <input type="checkbox"/> Presence/Participation in Treatment                                       | <input type="checkbox"/> Compliance with Title 22, Texas Administrative Code Ch 681.38 [e] [more than one therapist involved in treatment] |
| <input type="checkbox"/> Nursing/Medical Information   | <input type="checkbox"/> Other _____   |
| <input type="checkbox"/> Educational Information   |  |

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

\_\_\_\_ Initial here if you are refusing to sign authorization

This release expires in 1 year unless you specify a different date: \_\_\_\_/\_\_\_\_/\_\_\_\_.

OR initial here \_\_\_\_\_ if you wish this release to remain valid through the course of treatment regardless of the end date.

Release of Information continued:

***This office DOES NOT disclose information for the purpose of marketing, sales, or research. Information is only shared from this office, with signed consent, for purposes relevant to assessment and treatment.***

### **Revocation**

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to **Sharon L. Ward, MS, LPC, NCC** at 1015 Champions Drive, Suite 100 – Office 132, Aledo, TX 76008. 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. Sharon L. Ward, MS, LPC, NCC may refuse to release information that is deemed to be harmful to the patient as provided by law.

### **Form of Disclosure**

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

### **Redisclosure**

As client of this office, 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 understand that **Sharon L. Ward, MS, LPC, NCC** has no control over what is done with my personal health information once she releases it, with my consent.

