AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

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. Covered entities as that term is defined by HIPAA and the Texas Health and Safety Code §181.001 must obtain a signed authorization from the individual or the individual's legally authorized representative to disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing an insurance or health maintenance function, or as may be otherwise authorized by law. Please see this office's Notice of Privacy Practices for further information regarding disclosure of protected health information.

Patient Name (Please Print)

_____

Patient's Social Security Number (optional)

_____

Date of Birth

_____

Phone Number

_____

By signing this form, I authorize you to release confidential health information about me to the person(s) or entity listed below:

From ___ To ___

Matthew Magruder, LPC

9301 Collinfield Drive

Austin, TX 78758

Phone: 512-763-7565

From ___ To ___

_____

_____

_____

Phone _____

Austin, TX — 78759

ph: 512.763.7565 — e-mail: matthew@mlmagruder.com

For the purpose of: _____

Please release the following:

__Treatment Plan __Discharge Summary

__Summary of Entire Record __Verbal Communication

__Other (specify) _____

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

Your initials are required to release the following information:

_____ Mental Health Records (excluding psychotherapy notes) _____ Genetic Information (including Genetic Test Results)

_____ Drug, Alcohol, or Substance abuse records _____ HIV/AIDS Test Results and Treatment

I understand that the information released is for the specific purpose stated above. Any other use of this information without written consent of the patient is prohibited.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the individual or organization releasing information. I understand the revocation will not apply to information already released in response to this authorization or that is otherwise permitted by law without my specific authorization or permission, including disclosures to other covered entities as provided by Texas Health and Safety Code §181.154(c) and/or CFR §164.506(a)(1).

I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event or condition, this authorization will expire in twelve (12) months.

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ph: 512.763.7565 — e-mail: matthew@mlmagruder.com

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

_____

Patient signature (or parent, guardian or legal representative)

_____

Relationship to patient (if legal representative)

_____

Date

COMPLETE ONLY IF INFORMATION IS TO BE RELASED DIRECTLY TO PATIENT

I understand that my medical record may contain reports, and notes that only a psychotherapist can interpret. I understand and have been advised that I should contact my therapist regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries.

_____ _____

Patient signature (or parent, guardian or legal representative) Date

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