Comprehensive Counseling Care for the Family

Stephanie A. Richards, LPC-S, Registered Play Therapist Supervisor

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Authorization for Release of Mental Health Information

I hereby authorize STEPHANIE RICHARDS, LPC, PLLC to disclose the individually identifiable health information as described below, which may include psychotherapy notes. I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment for my health care will not be affected if I do not sign this form. I also understand that if I do not sign this form, federal and state law will prohibit, STEPHANIE RICHARDS, LPC, PLLC, from releasing the charts, notes, and knowledge of treatment of me or my minor child to the designated Recipient.

By accepting the records pursuant to this Authorization, the Recipient acknowledges that the protected health information covered by this release is confidential, privileged and protected by federal and state privacy statutes and regulations, and agrees that STEPHANIE RICHARDS, LPC, PLLC release of the individual identifiable health information will continue to be protected by federal and state privacy statues and regulations.

____ __________________

Print Client Name Date of Birth

Reason for Client's Initial Visit: ____

Description of information to be released: (check all that apply)

______ Diagnosis
______ Evaluation Reports
______ Billing Records
______ Other: ____
______ Treatment Summary
______ Treatment Recommendations
______ Psychotherapy Notes for Date(s) of service: __________________________

______ I deny permission for the release of client's protected health information

Description of the purpose of the use/or disclosure: ____

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The individually identifiable health information described herein shall be released to: (Name and Address and Phone/Fax of Recipient)

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I intend for this Authorization to remain in full force until I revoke it in ***writing*** to STEPHANIE RICHARDS, LPC, PLLC sent to 16607 BLANCO RD, STE 1404 SAN ANTONIO, TX 78232. The revocation will not affect any actions taken before the receipt of the written revocation, including if this authorization was obtained as a condition of payment and if the financially responsible party has a legal right to contest a claim. Further, it is my intent that a copy of this Authorization shall have the same effect as the original.

____ _____________________________

Printed Name of the Client or Client's Representative Date

____ _____________________________

Signature of Client or Client's Representative Relationship to the Client

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