Kalila B. Homann, MA. LPC, ADTR
1310 South First Street, Suite 200
Austin, Texas, 78704

# AUTHORIZATION FOR RELEASE OF INFORMATION FOR MENTAL HEALTH TREATMENT

I, _____ [whose Date of Birth is _____, Insert Name of Client],

authorize Kalila Homann to disclose to and/or obtain from:

_____
[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)
_____ Assessment
_____ Diagnosis
_____ Treatment Plan or Summary
_____ Current Treatment Update
_____ Medication Management Information
_____ Discharge/Transfer Summary
_____ Coordination of Care Plan
_____ Demographic Information

RELEASE OF INFORMATION
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.

REVOCATION
I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to:
Kalila Homann, LPC-S 1310 South 1st Street Austin, Tx 78704
I 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 expires on Date: September 1, 2016

CONDITIONS
I further understand that I 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 given a copy of this authorization for my records.

Client Signature: _____ ___Date:_____

_____
Signature of Parent, Guardian or Personal Representative: 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.).

Date:

Check here if patient/client refuses to sign authorization

_____
Therapist Signature: Date: