Massey Counseling, PLLC
Individual
Couple
Family

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19206 Huebner, Suite 104, San Antonio, TX 78258

# AUTHORIZATION TO USE & DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

I, _____, whose Date of Birth is _____, authorize Massey Counseling, PLLC
*[Insert Name of Patient/Client]*
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)

_____ Assessment
_____ Diagnosis
_____ Psychosocial Evaluation
_____ Psychological Evaluation
_____ Psychiatric Evaluation
_____ Treatment Plan or Summary
_____ Current Treatment Update
_____ Medication Management Information
_____ Presence/Participation in Treatment
_____ Nursing/Medical Information
_____ Educational Information
_____ Discharge/Transfer Summary
_____ Continuing Care Plan
_____ Progress in Treatment
_____ Demographic Information
_____Psychotherapy Notes*
(*Cannot be combined with any other disclosure)
_____Other_____
_____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 for another purpose please specify: _____
_____

**Revocation**
I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Massey Counseling, PLLC at 19206 Huebner Rd., Suite 104, San Antonio, TX 78258. 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 expires on the following date: _____ or as otherwise indicated:
_____

**Conditions**
I further understand that Massey Counseling, PLLC 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: _____
*[Insert explanation of any of not signing this authorization, which will depend on the services being provided].*

**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.

_____ _____
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.). _____

_____Check here if patient/client refuses to sign authorization _____
Signature of Staff Witness Date

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