**BARNWELL COUNSELING & FAMILY THERAPY, PLLC**
**2300 Highland Village Road, Suite 450**
**Highland Village, Texas 75077**

www.barnwellcft.com
(214) 663-8482

## CLIENT AUTHORIZATION FOR THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

This form allows the exchange of information between Barnwell Counseling & Family Therapy, PLLC and the person(s) to whom you grant consent below. The goal of such information exchange is to coordinate your care as best as possible. The information exchanged may include psychosocial evaluation, assessment, treatment plan, medical information, laboratory records, billing & scheduling information, psychotherapy notes, progress notes, case notes, and psychotherapy progress.

Client Name: _____ DOB: _____

I authorize Barnwell Counseling & Family Therapy, PLLC to disclose to and/or obtain from records of my/my child's health information:

Individual, Facility or Organization: _____

Phone Number: _____ Address: _____
(Street, City, State, Zip)

Information to be released includes:

- ❑ Assessment/Psychosocial Evaluation
- ❑ Current Treatment Update
- ❑ Educational Information
- ❑ Progress in Treatment
- ❑ Treatment Recommendations
- ❑ Diagnosis
- ❑ Treatment Plan or Summary
- ❑ Discharge/Transfer Summary
- ❑ Demographic Information
- ❑ Other _____

The purpose of this disclosure information is _____.

I understand that I have the right to revoke this authorization at any time by providing written notification. I further understand that a revocation of authorization is not effective to the extent that action has been taken in reliance on the authorization. This authorization expires on the following date: _____ or as otherwise indicated: _____.

I further understand that the provision of health care treatment to me cannot be conditioned upon my agreement to sign an authorization for the disclosure or use of my health information for purposes other than for treatment, payment, and healthcare operations.

I understand that there is the potential that 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 stricter than HIPAA and provides additional privacy protections.

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.

Client / Guardian Signature: _____ Date: _____

Printed Name: _____ Relationship to Client: _____

Signature of Therapist: _____ Date: _____