Kristina Stephens Counseling

Campbell Counseling Group, PLLC

HIPAA Release Authorization Form

I, _____, whose date of birth is _____ authorize Kristina Stephens, MA, LPC, RPT to disclose and/or obtain from _____, whose address is _____, phone number _____, fax number _____, the following information in regard to _____.

Description of Information to be Disclosed:

(Client should initial each item to be disclosed.)

_____ Assessment

_____ Diagnosis

_____ Psychosocial Evaluation

_____ Psychological Evaluation

_____ Treatment Plan or Summary

_____ Current Treatment Update

_____ Testing Information

_____ Educational Information

_____ Presence/Participation in Treatment

_____ Continuing Care Plan

_____ Progress in Treatment

_____ Other: _____

In addition, I authorize that this will include health information relating to (check if applicable):

_____ HIV/AIDS Test Results/Treatment

_____ Drug, Alcohol or Substance Abuse Records (Including those covered under 42 CFR part 2)

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 other purpose, please specify:

_____

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Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Kristina Stephens, MA, LPC, RPT at the given address. I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

Effective Time Period/Expiration

This authorization is valid until the earliest of following: the occurrence of death of the individual; the individual reaches the age of maturity; permission is revoked in writing; 120 days from the date of signing; or the following specific date:

Month: _____ Day: _____ Year: _____

Conditions

I further understand that Kristina Stephens, MA, LPC, RPT 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: could potentially impact your therapeutic process and treatment plan.

Form of Disclosure

Unless I have specifically requested in writing that the disclosure be made in a certain format, Kristina Stephens, MA, LPC, RPT reserves the right to disclose information as permitted by this authorization in any manner that she deems 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 that federal or state privacy laws may no longer protect the protected health information.

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Signature Authorization

I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health and Safety Code 181.154(c) and/or 45 C.F.R. 164.502(a)(1). Upon request, I will be given a copy of this authorization for my records.

_____

Printed Name

_____

Signature of Client Date

_____

Signature of Parent(s), Guardian or Legally Authorized Representative Date

If you are signing as representative, specify relationship to client:

_____ Parent(s) of Minor _____ Guardian _____ Other: _____

A minor individual's signature is required for the release of certain types of information, including, for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse and mental health treatment.

_____

Printed Name

_____

Signature of Minor Client Date

Refusal to Sign Authorization

_____ Initial here if client refuses to sign authorization

_____

Kristina Stephens, MA, LPC, RPT Date