Authorization to Disclose/Obtain
Mental Health Treatment Information

Name of Client: _____ **DOB:** _____

I, _____ [Name of Client or Guardian/Representative]

Authorize: Mary Ellen West, LCSW
3724 Jefferson Street, Suite 207, Austin, Texas 78731
Telephone (512) 201-2995

to disclose to and/or obtain from:

_____
[Name of Person or Title of Person or Organization]

_____
[address and/or phone number if available]

the following information:

Description of Information to be Disclosed **(**Please 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 the purpose is other than as specified above, please specify:

_____

Revocation I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Mary Ellen West, LCSW at 4131 Spicewood Springs Rd., Suite J-3 Austin, TX 78759. 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:_____.

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Conditions I further understand that Mary Ellen West, LCSW 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.

_____

Signature of 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