



Sharon L. Ward, MS, LPC, NCC
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Authorization to Disclose Mental Health Information

Consulting with certain individuals, professionals or organizations who are involved in treatment or caring for you or your child is an important part of providing the best possible treatment. This form allows you to give me permission to disclose to and obtain information from those entities which assist in assessment and treatment planning. Please complete a separate form for each entity. If listing an organization [such as a school], you may specify the names of those persons you wish to be included in this release.

This office DOES NOT disclose information for the purpose of marketing, sales, or research. Information is only shared from this office, with signed consent, for purposes relevant to assessment and treatment.

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to **Sharon L. Ward, MS, LPC, NCC** at 104 Maverick, Aledo, TX 76008. 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. Sharon L. Ward, MS, LPC, NCC may refuse to release information that is deemed to be harmful to the patient as provided by law.

Expiration

Unless sooner revoked, this authorization expires on the following date: one year from date of signing or as otherwise indicated: _____

Form of Disclosure

Unless you have specifically requested in writing that the disclosure be made in a certain format, I reserve the right to disclose information as permitted by this authorization in any manner that I deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Redisclosure

As client of this office, 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 understand that **Sharon L. Ward, MS, LPC, NCC** has no control over what is done with my personal health information once she releases it, with my consent.



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Authorization to Disclose Mental Health Information

Client's Name [print] _____ Date of Birth _____

Parent/Guardian Name [print] _____ Relationship _____
[if client is under age 18]

authorize **Sharon L Ward, MS, LPC, NCC** to disclose information to and/or obtain information from:

Name _____ Relationship _____

Address _____

Phone _____ Fax _____ email _____

Name of other personnel at this agency that may receive or disclose information _____

Description of Information to be Disclosed - please **initial**

_____ Assessment and Evaluation [testing,
questionnaires, clinical observation]

_____ Billing/payment information

_____ Diagnosis

_____ Treatment Plan/Update/Summary

_____ Medication Management Information

_____ Presence/Participation in Treatment

_____ Nursing/Medical Information

_____ Educational Information

_____ Discharge/Transfer Summary

_____ Demographic Information

_____ Alcohol/Drug history or use

_____ Information needed for couples or marital therapy

_____ Information needed for treatment of child

_____ Other _____

I will be given a copy of this authorization for my records upon my request.

Signature _____ Date _____

_____ Check here if patient/client refuses to sign authorization

Signature of Staff Witness

Date