Melissa Earls, LPC ~ Peace of Mind Counseling
3335 Cartwright Rd., STE 50, Missouri City, TX. 77459
Office: 281.788.7975 Fax: 281.407.6217
www.peaceofmindcounseling@yahoo.com

RELEASE OF CONFIDENTIALITY & RECORDS REQUEST INFORMATION:

All Requests are processed within 30 business days from the date of the receipt of this form and payment. Payments can be processed via the website at www.peaceofmindcounseling.org. Please provide $25 for the first 20 pages, and 50 cents for each page thereafter. You will be notified if your records exceed 25 pages within 3 days of the receipt of the request and payment. Please return the request via fax (281.407.6217) or email (peaceofmindcounseling@yahoo.com).

I, _____ do hereby agree to allow Melissa Earls, LPC to release confidential information on _____, obtained during my/my child's session to _____. I understand that _____ agrees maintain the confidentiality of the information related from Melissa Earls, LPC, and any progress notes, treatment plans or testing materials contain confidential and/or privileged material. It is intended solely for the person or entity to which it is addressed. Any review, retransmission, dissemination, or taking of any action in reliance upon this information by persons or entities other than the intended recipient is prohibited.

Authorization for Use/Disclosure of Information: I voluntarily consent to an authorize **Melissa Earls, LPC** to disclose my health information during the term of this Authorization to the recipient(s) that I have identified below.

I authorize my health care information to be released to the following recipient(s):

Name:_____

Address:_____

Fax: _(_____)_____-_____ EMAIL: _____@_____

PURPOSE: I authorize the release of my health information for the following specific purpose:

_____

(Note: "at the request of the patient" is sufficient if the patient is initiating this Authorization)

Information to be disclosed: I authorize the release of the following health information: (check the applicable box below)

- ❑ All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me.[1]
- ❑ Only the following records or types of health information: _____.

TERM: I understand that this Authorization will remain in effect:

- ❑ From the date of this Authorization until the _____ day of _____, 20___.
- ❑ Until the Provider fulfills this request.
- ❑ Until the following event occurs:_____

CONFIDENTIALITY

Information about the diagnosis, evaluation, or treatment of the above client is confidential information that this office is being authorized by the client or client's parent/guardian to disclose only to authorize persons listed above. Only the client or client's parent/guardian may give written permission for release of this information before it can be released to another person or agency. Confidentiality will be maintained in all other respects.

In regards to the Health Insurance Portability and Accountability Act (HIPAA) of 1996, the client or client's parent/guardian have been made aware of how medical information may be used and disclosed and how to can get access to this information.

_____ _____
Client/Parent/Guardian Signature Date

_____ _____
Witness Date

_____ _____
Therapist Signature Date

_____