Sharon L. Ward, MS, LPC, NCC

1015 Champions Drive
Suite 100 – Office 132
Aledo, TX 76008

4200 S. Hulen Street
Suite 450
Fort Worth, TX 76109

Telephone: 817/441-9973 Fax: 877/775-3387
sharonwardcounseling.com lpc.ward@yahoo.com

FORM 6: Authorization to Disclose Mental Health Information

This form allows you to give me permission to disclose to and obtain information from those entities which assist in assessment and your treatment planning. Please complete a separate form for each entity [office, agency, physician, dietitian, spouse, parent, grandparent etc.] If listing an organization [such as a school], you may specify the names of those persons you wish to be included in this release. You may receive a copy of this authorization for your records upon your request.

Your [or child's] Name [print] _____ Birthday_____

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

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

Provider/Other
Name:_____

Circle one: psychiatrist/counselor/parent/spouse/dietitian/child/ physician/agency/school/lawyer/grandparent/insurance/hospital

other_____

Address _____

Phone _____ Fax _____email _____

Name of other personnel at this agency, hospital, school [etc] 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
_____ Alcohol/Drug history or use
_____ Information needed for couples or marital therapy
_____ Information needed for treatment of child
_____ Compliance with Title 22, Texas Administrative Code
_____Ch 681.41 [l] [more than one therapist involved in treatment]
Other _____

Signature _____ Date_____

_____Initial here if you are refusing to sign authorization

This release expires in 1 year unless you specify a different date: _____/_____/_____.
OR initial here _____if you wish this release to remain valid through the course of treatment regardless of the end date.

Release of Information continued:

<u>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.</u>

<u>Revocation</u>

I understand that I have a right to revoke this authorization, <u>in writing</u>, at any time by sending written notification to **Sharon L. Ward, MS, LPC, NCC** at 1015 Champions Drive, Suite 100 – Office 132, 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.

<u>Form of Disclosure</u>

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.

<u>Redisclosure</u>

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.