Sharon L. Ward, MS, LPC, NCC
104 Maverick St. **4200 S. Hulen, Suite 450**
Aledo, TX 76008 **Fort Worth, TX 76109**

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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] Sarah Johnson Birthday 1-1-2000

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:

Name Dr Sigmund Freud

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

other_____

Address 15321 Adlers Court, Fort Worth TX 76101

Phone 817-346-5555 Fax 817-777-5555 email drfreud@psychmail.com

Name of other personnel at this agency, hospital, school [etc] that may receive or disclose information _____
Nurse practitioner Anna Pankejeff

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

- sj Assessment and Evaluation [testing, questionnaires, clinical observation]
- _____ Billing/payment information
- sj Diagnosis
- sj Treatment Plan/Update/Summary
- sj Medication Management Information
- _____ Presence/Participation in Treatment
- _____Nursing/Medical Information
- _____ Educational Information
- _____ Discharge/Transfer Summary
- sj 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 11/9/22

_____Initial here if patient/client refuses to sign authorization

This release expires in 1 year unless you specify a different date: _____/_____/_____.
OR _____This release is valid through the course of my treatment regardless of the end date.
[initials]

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 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.

<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.