Susan I. Bates, MA,LCDC
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Austin, TX 78703
512-689-6595

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

This form when completed and signed by you, authorizes me to release protected information from your clinical record to the person you designate.
I, _____________________, voluntarily and without coercion, authorize Susan I. Bates, MA, LCDC to discuss my case verbally with, and/or exchange a copy of my treatment records via mail, electronic mail, or facsimile with:

(Name) ____
(Street)____
(City, State, Zip)____
(Phone/Email) ____

I understand that the specific type of information to be disclosed may include Protected Health Information, a history of and information regarding the diagnosis and treatment of drug or alcohol abuse, Acquired Immune Deficiency Syndrome, other medical conditions, and/or psychiatric disorders. At my request my therapist may release information that includes the following:

_______Consent Forms
_______History
_______ Treatment Plan
_______Legal Information
_______Psychological Assessment
_______Physician's Reports/Notes
_______Progress in Treatment
_______Diagnoses
_______Clinical Progress Notes
_______Termination Summary

Restrictions, if any: ____

The Purpose for this Release:

_______Legal Circumstances
_______Coordination of Treatment
_______Insurance Purposes
_______Disability Determination
_______Continuity of Care
_______Other

I release Susan I. Bates, MA, LCDC from all legal responsibility or liability resulting from the release of such information and I waive, on behalf of myself, my heirs and assigns and any persons who may have an interest in the matter, all provisions of law relating to the disclosure of such information. This authorization shall remain in effect until the date of revocation written below. I understand that I may revoke this consent at any time by sending written notice to my therapist. However, my revocation will not be effective to the extent that my therapist has taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. Further, such revocation does not include any information released in good faith prior to the date of revocation.
I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of this information and may no longer be protected by the HIPAA Privacy Rule.

___________________________________ ____________________
Signature of client Date

___________________________________ ____________________
Signature of witness Date

____
Date of revocation

PROHIBITION ON DISCLOSURE: To the party receiving this information: This Protected Health Information has been disclosed to you from records whose confidentiality is protected by federal law. FEDERAL REGULATION (42 CFR Part 2) prohibits you from making any further disclosure of it without *the specific written consent* of the person to whom it pertains, their legal representation, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information IS NOT sufficient for that purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Form updated: 6/2015