On Deck Counseling, PLLC
Release of Information Consent

Office: 817-581-4730 FAX: 817-426-2276

Client's Name: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____
Phone: _____

I, _____ , authorize **Iris L. Kuykendall, MS, LPC,** (license #60678),

to: _____ send _____ receive the following information (from/to)

Name: _____ Title: _____
Address: _____ City: _____ State: _____ Zip: _____
FAX: _____ Phone: _____

A SEPARATE AUTHORIZATION, AS DEFINED BY HIPAA, IS REQUIRED FOR *PSYCHOTHERAPY NOTES.

___ Diagnosis ___ Treatment plans
___ Progress reports ___ Summary reports
___ Dates of Treatment ___ Phone consultation
___ *Psychotherapy Notes

___ Other, specify _____

The above information will be used for the following purposes:
___ Planning appropriate treatment or program
___ Continuing appropriate treatment or program
___ Determining eligibility for benefits or program
___ Case review ____ Updating files
___ Other (specify) _____

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules. I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after 1 year this consent will automatically expire. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization.

Your relationship to client:
__Self __Parent/legal guardian __Personal representative
__Other (describe)_____

If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

Client's Signature: _____ Date: __/_____/_____
Parent/guardian/personal representative (if applicable)
Signature: _____ Date: __/_____/_____