Peltier Family Counseling, PLLC
Mariah Peltier, M.Ed., LPC
1333 W. McDermott Drive, Suite 150
Allen, TX 75013
Phone: (972) 447-8280

Authorization for Use and Disclosure of Protected Health Information

Name: _____ Date of Birth: _____
Address: _____
Social Security Number: _____ Contact Number(s):_____

I, the undersigned client or legal guardian, hereby authorize ___ verbal and/or ___written information to be released by Mariah Peltier, LPC to:

Name: _____ Phone: _____
Fax: _____ Address: _____
_____

Information to be released:

___ Initial Evaluation
___ Psychosocial Assessment
___ Progress Notes
___ Consultation
____ Diagnosis
____ Treatment Planning
____ Discharge Summary
____ Other _____

Release of Information is for the following purpose: _____

- I understand that the information released may include mental health, substance abuse, or HIV/AIDS information.
- I understand that this authorization is voluntary and that treatment by Mariah Peltier, LPC cannot be conditioned on the signing of this authorization.
- I understand that there may be a charge, payable in advance, for the copying and conveyance of records released.
- I understand that this authorization may be withdrawn by me in writing at ay time. I cannot, however, take exception to actions that have taken place before I withdrew my consent.
- I understand that the information disclosed by this authorization may be subject to re-disclosure by the recipient and will not longer be protected. Mariah Peltier, LPC is released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.
- I understand that the information being release is from records whose confidentiality is protected by state and federal law.

Client or Guardian Signature: _____ Date: _____
Witness: _____ Date: _____