JESSICA ACKER LPC INC

12321 TIERRA HUMEDA, EL PASO TX 79938

915-691-7130

AUTHORIZATION FOR DISCLOSURE, USE, OR RECEIPT OF PROTECTED HEALTH INFORMATION (PHI)

Client Name: ______________________ DOB: ____________

I authorize the staff at Jessica Acker LPC, Inc., to disclose/use/receive the following protected health information, whether oral, written or electronic (check all that apply):

___Psychiatric Evaluation
___Psychological Test Results
___Mental Status Information
___Treatment plans
___Progress Notes/Reports
___Diagnosis
___Crisis Intervention Reports
___Chemical Recovery History
___Dates of Hospitalizations
___Court/Agency Documents
___Medical Reports/Records
___Medical History
___Discharge Summary
___Appointment times/dates
___Other: ____________

I also authorize the disclosure/use/receipt of my health information regarding (**initials**):
____Psychiatric and Psychological Records
____HIV/AIDS/STD information
____Alcohol and drug abuse treatment information

(Person Bringing the child)

Jessica Acker LPC, Inc. may disclose to/receive from: ______________________
(Name of person, organization, or facility)

The purpose for disclosure is:
__X__At my request
_____ To discuss with my family the care and treatment I receive
_____ To coordinate care with other health care professionals
_____ Other ______________________

**Note: I understand I do not have to sign this authorization to receive treatment or payment processing from Jessica Acker LPC, Inc. I may revoke this authorization in writing at any time. If I do so, it would not affect any actions already taken by someone in reliance on this authorization. If I wish to revoke this authorization, I shall do so by delivering a signed and dated letter to Jessica Acker LPC, Inc stating the reason for revocation. The revocation will be effective the date it is received by Jessica Acker LPC, Inc. I also understand that once the designated staff at Jessica Acker LPC, Inc. discloses protected health information, any person or organization that receives it may re-disclose it. Patient privacy laws may no longer protect that information. I understand that I may request a copy of this authorization and that a photocopy or facsimile is as valid as the original.

Unless this authorization is revoked earlier in writing, it will expire one year from today's date on: _____

______________________ ______________________ ____________
Client/Parent/Guardian Signature Relation to client Date

THIS FORM IS USED TO DESIGNate another adult to bring the child to or from Session