TERRI LITICKER LCSW
214-587-3454
AUTHORIZATION FOR USE AND DISCLOSURE OF CONFIDENTIAL PROTECTED HEALTH/PSYCHOLOGICAL INFORMATION

I, _____, (client's name or authorized representative)

hereby authorize _Terri Liticker LCSW_____ (provider) to release from/ to:

_____(Recipient Name)

_____
(Street Address) (City, State, Zip)

Telephone: Fax:

The following information from the psychological or financial record of: Client Name: _____ ____

Date of Birth: _____ Dates of Treatment: _____ _____

Information to be released:

____ Intake/Treatment plan ____ Therapy Progress Notes

____ Oral Communications ____ Other (specify): _____

The information specified above is to be released for the following purpose(s):

___ Treatment/Consultation ____ Client Request ____ Billing or Claims

____ Attorney/Subpoena ____ Social Security ____ CASA reports

____ Other (specify): _____

2. Drug and/or Alcohol Information Records Release

I understand that if my medical or billing records contain information in reference to drug and/or alcohol use or treatment, I specifically agree to its release.

Check one & Initial: **____ Yes ____ No ___X__ Initials**

3. HIV/AIDS Information Records Release

I understand that if my medical or billing records contain information in reference to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment, I agree to its release.

Check one & Initial: **____ Yes ____ No __X___ Initials**

4. **Psychiatric or Mental Health Information Records Release**

I understand that if my medical or billing records contain information in reference to psychiatric or mental health testing or treatment, I agree to its release.

Check one & Initial: **_X___ Yes ____ No _____ Initials**

5. **Right to Revoke Authorization**

I understand that, without exception, I have the right to revoke this authorization in writing. I further understand the consequence of any such revocation.

6. **Re-disclosure**

I understand that information disclosed by this authorization may be subject to re- disclosure by the recipient and will no longer be protected by the Health Information Portability and Accountability Act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

7. **Copy Provided**

I understand that I will receive a copy of this authorization after signing it.

8. **Expiration**

This authorization will automatically expire in one (1) year from the date of my signature or unless revoked prior to the time or unless otherwise specified as follows.

_____.

9. **Signature of Client or Personal Representative**

I understand that the signing of this authorization is not a condition for continued treatment, payment, enrollment, or eligibility for health plan benefits.

_____ _____
Signature of Client/ Representative Name of Client/Representative

_____ _____
Date Description of Representative's Authority

_____
Client's Date of Birth