

EnGedi Life Care, PLLC

Treatment Disclosure Authorization

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of Protected Health Information (PHI). Covered entities as that term is defined by HIPAA and Texas Health & Safety Code § 181.001 must obtain a signed authorization from the individual or the individual's legally authorized representative to disclose that individual's PHI. Authorization is not required for disclosures related to treatment, payment, health care operations, performing an insurance or health maintenance organization function, or as may be otherwise authorized by law. Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws. **No disclosure can occur unless this form is completely filled out.**

Client Information *(provide all information)*

Name _____
Last First Middle

Birth Date _____ (mm/dd/yyyy)

Address _____

City _____ State ____ Zip _____

Phone _____

Email _____
(optional)

When therapy involves more than one person (e.g., couple, family, group), a separately signed form is required from each person before the release of any information is permitted.

Therapist

Information to disclose to third party

Reason for disclosure *(choose only one)*

EnGedi Life Care, PLLC
 1464 E Whitestone Blvd Ste 202
 Cedar Park, TX 78613
 512-528-5356
 contactus@elctherapy.com

- Summary of progress
- Billing information
- Mental Health Records, no therapy notes
- Other _____
- No information to be disclosed to third party

- Treatment/Continuing Care
- Billing or Claims
- Insurance
- Legal Purposes
- Disability Determination
- School or Employment
- Other _____

Third Party *(provide all information)*

Information to disclose to therapist

Name _____
 Address _____
 City _____ State ____ Zip _____
 Phone _____
 Email _____
(optional)

- Summary of progress
- Billing information
- Mental Health Records, no therapy notes
- Other _____
- No information to be disclosed to therapist

Effective Time Period. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): _____ (mm/dd/yyyy)

Right To Revoke. I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named to receive the PHI. I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

Signature Authorization. I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to other covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.506(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws. I also authorize the transmittal of this Treatment Disclosure Authorization from/to the disclosing or receiving party by fax or e-mail, understanding that electronic communication is not secure and may be seen by a third party.

Signature _____ Date _____
Client's Signature or Client's Legally Authorized Representative (mm/dd/yyyy)

Representative's Printed Name (if applicable) _____

Representative's relationship to client: Parent of minor Guardian Other _____

Signature of a minor is required for release of Mental Health PHI (Tex. Fam. Code § 32.003)

Signature _____ Date _____

To ensure privacy you may fax completed form to EnGedi Life Care, PLLC at 888-971-3931.