Open Heart Counseling ATX
Hope & Healing After Trauma

# AUTHORIZATION TO DISCLOSE INFORMATION

**Name of Child/Client:**

_____
Last First

_____
Date of Birth Age

**I authorize the following to disclose information regarding the child/client:**

Lacey Fisher, LPC-S, RPT-S
8101 West Highway 71 Austin, TX 78735
254.718.8373 Lacey@openheartcounselingatx.com

**Who can receive the information?**

_____
Person/Agency Name Title

_____
Address City State Zip Code

_____
Phone Fax Email

**Reason for disclosure:**

- ☐ Treatment/Continuing Care
- ☐ Legal Purposes
- ☐ Disability Determination
- ☐ School
- ☐ Person Bringing Child to Counseling
- ☐ Employment
- ☐ Other:_____

**What information can be disclosed?**

- ☐ All health information
- ☐ Progress Information
- ☐ Discharge Summary
- ☐ Treatment Plans
- ☐ Dates of Treatment
- ☐ Past/Present Medications
- ☐ Other:_____

EFFECTIVE TIME PERIOD: This authorization is valid until mental health services are terminated with Lacey Fisher. If services are terminated and further disclosure is requested, a new authorization form must be signed and completed.

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice to Lacey Fisher. The written notice will state my intent to revoke this authorization to the agency named under "Who can receive this information." 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 revocations or that is otherwise permitted by court order or required by state law. State law requires the reporting of threats of violence or harm to self or others, or child abuse and neglect.

_____ _____
Client or Parent/Guardian Signature Date Lacey Fisher, LPC-S, RPT-S Date