THERAPY DALLAS

Psychological Services for Children, Adolescents, and Adults

12800 Hillcrest A124, Dallas, TX 75230 • 214-755-6119 • www.therapydallas.com

AUTHORIZATION TO RELEASE/RECEIVE PERSONAL HEALTH INFORMATION*

PATIENT'S NAME: _____ BIRTH DATE: _____

I, _____ hereby give my consent to Therapy Dallas to release and receive personal health information contained in my Clinical Record regarding:

☐ mental health ☐ medical history ☐ family history ☐ other: _____

To/from:

Psychiatrist: _____

Phone: _____

Physician: _____

Phone: _____

Prior Therapist: _____

Phone: _____

Other: _____

Relationship to Patient: _____

Phone: _____

Other: _____

Relationship to Patient: _____

Phone: _____

for the purpose(s) of ("Consultation" if left blank):

_____ .

In addition to authorizing my therapist to consult with the above-listed individuals *outside Therapy Dallas*, I also give my consent for my therapist to exchange with the below *Therapy Dallas therapist(s)* personal health information contained in my Clinical Record, for the purposes of clinical consultation:

Therapy Dallas Therapist(s): _____

_____

I understand that this authorization is valid for 1 year after the last date of service unless otherwise indicated here: _____ . I understand that I may, via written request, withdraw my consent at any time, and that I have a right to receive a copy of this authorization form. I also understand that the information being disclosed pursuant to this authorization to individuals outside Therapy Dallas may be subject to redisclosure by the recipient, and may no longer be protected by this privacy rule.

_____	_____	_____
Name of Patient	Signature	Date

* Compliant with the *Health Insurance Portability and Accountability Act* (HIPAA).