OpenDoor

Counseling and Assessment Services, PLLC

An Association of Individual Professionals

109 Woodrow Lane, Suite 300 Denton, TX 76205 Phone: (940) 565-0939
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AUTHORIZATION FOR
THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, ____, the undersigned client of OpenDoor Counseling and Assessment Services, (hereinafter referred to as "OpenDoor"),do hereby authorize OpenDoor, my treating mental health provider, to disclose **any and all** protected health information in my file, included by not limited to psychotherapy notes to the following persons and/or agencies:

____(Recipient Name)
____(Street Address)
____(City, State, Zip)
Telephone:___________________ Fax: _______________________ E-mail:______________________________

The following information from the medical or financial record of:_____________________________________
____:

Date of Birth: ___________ Dates of Treatment: _______________

Social Security#: ___________

Information to be released:

____ Consultation Reports ____ Discharge Summary ____Itemized Bill

____Progress Notes ____ Other (specify): __________________________________

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

____ Treatment/Consultation ____ Patient Request ____ Billing or Claims

____ Attorney ____ Social Security

____ Other (specify): ____

Patient Initials:______

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 _____ Initials**

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 _____ Initials**

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: **____ Yes ____ No _____ Initials**

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.

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 and officers are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Copy Provided

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

Expiration

This authorization will automatically expire in two (2) years from the date of my signature or unless revoked prior to the time or unless otherwise specified as follows.

____

____

I also give authorization to obtain **any and all** protected health information from the same above referenced persons and/or agencies:_________**(Initials)**

I acknowledge that I have the right to revoke this authorization in writing at any time to the extent OpenDoor has not taken action in reliance on this authorization. I further acknowledge that even if I revoke this authorization, the use of any disclosure of my protected health information could be possibly still be compelled by Court Order under state law as indicated in the copy of the Privacy Notice of OpenDoor that I have received and reviewed.

I acknowledge that I have been advised by OpenDoor of the potential of disclosure of my protected health information by the authorized recipients and that it will no longer be protected by the federal Privacy Rule.

Signature of Patient or Personal Representative/Parent

I understand that the signing of this authorization is not a condition for continued treatment.

____ ____

Signature of Patient/ Representative/Parent Name of Patient/Representative/Parent

____ ____

Date Description of Representative's Authority

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Patient's Date of Birth

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