Kim Saltzman
LICENSED PROFESSIONAL COUNSELOR

26113 Oak Ridge Drive, Ste C | The Woodlands, TX 77380 | 281.989.5106 | www.kimsaltzman.com | kim@kimsaltzman.com

AUTHORIZATION CONSENT FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

NOTICE TO RECIPIENTS OF INFORMATION

This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulations (42 CFR Par2) prohibit you from making further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

PERSON, AGENCY OR ENTITY TO WHOM INFORMATION IS TO BE RELEASED:

Name _____

Address _____

City _____

State _____ ZIP _____

Phone _____ Fax _____

Email _____

THIS DOCUMENT AUTHORIZES KIM SALTZMAN MA, NCC, LPC TO DISCLOSE INFORMATION CONCERNING:

Name(s) _____

Address _____

City _____

State _____ ZIP _____

Date of Birth _____

Social Security Number _____

I, the undersigned, hereby consent to, direct and authorize **Kim Saltzman MA, NCC, LPC** to release or disclose confidential records or protected healthcare information pertaining to my treatment and counseling process with _____ the above stated person, agency or entity.

THE RECORDS OR PROTECTED HEALTH INFORMATION TO BE RELEASED AND DISCLOSED SHOULD INCLUDE:

- ○ Initial Assessment/History
- ○ Treatment Plan
- ○ Progress Notes
- ○ Billing Records
- ○ Transfer/Termination Summary
- ○ Tests Taken and Testing Scores
- ○ Any and all records and/or protected health information
- ○ Other (specify)

_____

_____

THE PURPOSE OF THIS DISCLOSURE IS TO:

- ○ Facilitate treatment
- ○ Comply with legal requirements
- ○ Facilitate financial considerations for third-party payers
- ○ Other (specify)

_____

_____

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

I acknowledge that I have been advised by **Kim Saltzman MA, NCC, LPC** of the potential of the redisclosure of my protected health information by the authorized recipients and that it will no longer be protected by the Federal Privacy Rule. I acknowledge and understand I am waiving my right to confidentiality with respect to the records and protected health information released pursuant to this consent.

I further acknowledge that the treatment provided to me by **Kim Saltzman MA, NCC, LPC** was not conditional on my signing this authorization.

This consent is subject to revocation at any time, except to the extent that action has been taken in reliance thereon. This consent, unless sooner revoked, is valid until _____, 20_____ (Condition date or event upon which consent will expire without express revocation).

SIGNED this _____ of _____ , 20_____.
(day of the week) (month and date)

Client _____

Address _____

City _____

State _____ ZIP _____

Phone _____ Fax _____

Email _____

Date of Birth _____

Social Security Number _____

I acknowledge that I have received a copy of this signed authorization from **Kim Saltzman MA, NCC, LPC** this _____ of _____ , 20_____.
(day of the week) (month and date)

_____
Client Signature