Creative Solutions Counseling
9800 Hillwood Parkway, Suite 140
Fort Worth, TX 76177

RELEASE OF INFORMATION

I, _____, parent/guardian of _____ whose date of birth is _____ authorize Mariah Snapp, LCSW to disclose to/and or obtain from _____(Name of agency)
_____ (address/phone number) the following information:

Description of Information to be disclosed:
(Please initial each item to be disclosed)

___ Assessment
___ Testing Information
___ Diagnosis
___ Educational Information
___ Psychosocial Evaluation
___ Presence/Participation in Treatment
___ Mental Health Evaluation
___ Continuing Care Plan
___ Treatment Plan or Summary
___ Progress in Treatment
___ Current Treatment Update
___ Other _____

Purpose
This information may be used or disclosed in connection with mental health treatment, payment, or healthcare operations.
If the purpose is other than as specified above, please specify:
_____

Revocation
I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Mariah Snapp, LCSW at Creative Solutions Counseling 9800 Hillwood Parkway, Suite 140, Fort Worth, TX 76177. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration
Unless sooner revoked, this authorization expires one year from date signed or as otherwise indicated:_____

Conditions
I further understand that Mariah Snapp, LCSW will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this

authorization may have the following consequences: could impact your therapeutic process and treatment plan.

Form of Disclosure
Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Redisclosure
I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be re-disclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections.

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 covered entities as provided by Texas Health and Safety Code 181.154(c) and/or 45 C.F.R. 164.502(a)(1). Upon request, I will be given a copy of this authorization for my records.

_____

Printed Name

_____

Signature of Client Date

_____

Signature of Parent(s), Guardian or Legally Authorized Representative Date

_____

Relationship to client

A minor individual's signature is required for the release of certain types of information, including, for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse and mental health treatment.

_____

Printed Name

_____

Signature of Minor Client Date