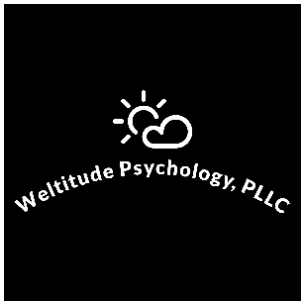

Weltitude Psychology, PLLC
San Marcos, TX 78666
512-222-4686
privacy@weltitudepsychology.com

Authorization to Release/Obtain/Exchange Confidential Information

INSTRUCTIONS: In order for your provider and/or Weltitude Psychology, PLLC to release, obtain, or exchange confidential information, this authorization must be completed according to these instructions. All information related to identification, location, and communication of those involved in the release of information must be provided. This is necessary to ensure that information is released only to those you intend. For your protection, if this form is incomplete, we will not release or request the release of any information OR you may be asked to complete the form again. If you need assistance in completing this form, contact Weltitude Psychology, PLLC at 512-222-4686.

I, Client Legal Name - First Last

Date of Birth

Social Security No.

CLIENT STREET OR MAILING ADDRESS

CLIENT CITY/STATE/ZIP

CLIENT PHONE

AUTHORIZE my provider:

Therapist Name

and/or the clinical or administrative staff at Weltitude Psychology, PLLC to

Select all that apply

- [ ] Release or Disclose Confidential Information To
- [ ] Obtain Confidential Information From
- [ ] Exchange Confidential Information With
- [ ] Release to Myself

Release or Disclose Confidential Information To:
Authorization is to release or disclose information only to the identified sources listed below.

Obtain Confidential Information From:
Authorization is to obtain information from another source that is listed below.

Exchange Confidential Information With:
Authorizes the two designated parties to share information. This option provides the greatest flexibility for communication.

Release to Myself:
To individual client for use at their own discretion.

*Note, if releasing information to yourself, please insert your information below.

NAME OF PERSON/ORGANIZATION/FACILITY

STREET OR MAILING ADDRESS

CITY/STATE/ZIP

PHONE

FAX NUMBER

The confidential information to be disclosed, released, exchanged, or obtained is:

Select all that apply:

- [ ] Assessment Summary and Recommendations
- [ ] Diagnosis or Diagnostic Impression
- [ ] Psychological Evaluation Report
- [ ] Treatment Plan or Summary
- [ ] Current Treatment Update or Progress in Treatment
- [ ] Presence/Participation in Treatment
- [ ] Continuing Care Plan or Mental Health Maintenance Plan
- [ ] Progress or Psychotherapy Notes

If 'Other' Please Specify Here:

- [ ] Date(s) of attendance and type(s) of services received
- [ ] My entire record
- [ ] Information regarding mental health
- [ ] *Other, Please Specify

The purpose of releasing, disclosing, exchanging, or obtaining the confidential information is for:

Select all that apply

- [ ] At my request (Request of the client)
- [ ] Participation of a family member or other person(s) in treatment
- [ ] Legal proceedings or matters
- [ ] Disability accommodations or benefits
- [ ] Continuity of care or collaboration of care
- [ ] Other *Please Specify

If 'Other' Please Specify Here:

Restrictions or limitations, please specify here:

(Please Specify)

Unless sooner revoked, this authorization expires:

Select One

- ○ One time (i.e., after purpose of this authorization is completed as outlined in this document)
- ○ Thirty (30) days after the date of authorization.
- ○ Sixty (60) days after the date of authorization.
- ○ Six (6) months after the date of authorization.
- ○ One (1) year after the date of authorization.

If 'Other' Please Specify Here:

- ◯ Other *Please Specify

Form of Disclosure, Release, or Exchange of confidential information

If you desire, you may limit the disclosure, release, or exchange of your confidential information to one of the following methods:

Choose One

- ◯ No preference of method of disclosure
- ◯ Verbal Only
- ◯ Paper or Electronic Only

By signing this document I understand the following:

I understand matters discussed on this form.

I release and Weltitude Psychology, PLLC from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification. 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.

I understand that my provider and Weltitude Psychology, PLLC will not condition my treatment on whether I give authorization.

I understand that authorizing the disclosure of health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to obtain treatment unless the sole purpose for the treatment is the disclosure of for which the authorization is necessary.

I understand that I may inspect or copy the information to be used or disclosed, as provided by federal government's rules, which are in the United States Code of Federal Regulations at section 164.524 and can be found at: https://www.ecfr.gov/

I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed 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 protection.

I understand that the my provider and Weltitude Psychology, PLLC cannot guarantee confidentiality of information after it is released.

Signature of Client

Date

mm/dd/yyyy