AUTHORIZATION TO EXCHANGE CONFIDENTIAL INFORMATION

I (name of client) _____ (Parent/guardian of _____)

hereby authorize the mutual exchange of confidential information regarding my/my child's treatment by New Life Counseling Center, PLLC therapist _____ :

(Name & Title) _____

(Address) _____

(Phone/Fax) _____

(Email) _____

Methods of disclosure/communication permitted (please circle): Mail Phone Fax Electronic (email)

Information to be disclosed:	Specific purpose for disclosure:
_____ Verify participation in therapy	_____ Coordinating treatment
_____ Summary of progress	_____ Billing or Claims
_____ Billing information	_____ Legal purposes
_____ Mental health records, no therapy notes	_____ School or employment
_____ Other: _____	_____ Other: _____

I authorize the mutual exchange of said information for the continuity of my/my child's psychological services and care. Furthermore, I understand that I have a right to receive a copy of this authorization. And if I choose to cancel or modify this authorization, I must submit this in writing to my NLCC therapist.

This authorization expires 30 days after termination of psychotherapy, upon receipt of written revocation of this authorization or upon this specified date or event: _____

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 other entities as provided by Texas Health & Safety Code 181.1549(c) re: child/elder neglect/abuse. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws. I also authorize the transmittal of this Authorization from/to the disclosing or receiving party by fax or email, understanding that electronic communication is not secure and may be intercepted by a 3rd party.

Client Name (print) _____Date _____ Signature _____

Client Name (print) _____Date _____ Signature _____

Parent/Guardian Name _____Date _____ Signature _____

NLCC therapist Name _____Date _____ Signature _____