Genuine Life Psychology & Wellness, PLLC
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Phone 972.742.2186 | Fax 469.232. 9943

Jennifer S. Hartman, Ph.D.
Licensed Psychologist, Owner

Authorization for Use and Disclosure of Protected Health Information

Patient's Full Legal Name_____ Date of Birth_____

Phone #_____Legal Mailing Address_____

I, the undersigned, authorize the exchange of information between Dr. Jennifer Hartman and:

_____
(Therapist, Doctor, Hospital, Attorney, etc.) Phone Number

_____
Address (Street, City, State, Zip Code) Fax Number

Information to be released or accessed:

- ❒ My entire clinical health record
- ❒ Initial Intake Report
- ❒ Progress Notes
- ❒ Treatment Plan
- ❒ Assessment and Treatment Summary
- ❒ Termination/Discharge Report
- ❒ Psychological Evaluation Report
- ❒ Hospital Reports
- ❒ Past/Present Medications
- ❒ Verification of Attendance
- ❒ Other_____

Protected Health Information is needed for

- ❒ Coordination of Medical/Wellness Care
- ❒ Legal Purposes
- ❒ Personal Use
- ❒ Billing/Insurance
- ❒ Coordination with Family/Legal Representative
- ❒ Disability Determination
- ❒ Employment/School
- ❒ Other_____

Your initials are required to release the following information:
_____Mental Health Records (excluding psychotherapy notes)_____Drug, Alcohol, or Substance Abuse Records
_____Genetic Information (including Genetic Test Results) _____HIV/AIDS Test Results/Treatment

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 & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). 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 understand that I can withdraw my permission at any time by giving the written notice stating my intent to revoke this authorization. This authorization will remain in effect for the duration of treatment with Dr. Hartman unless I revoke the authorization prior to that time or unless otherwise specified by date, event, or condition as follows (optional):

_____

Date_____

_____
Signature of Client (or Legally Authorized Representative)

_____
Printed Name of Client or (Legally Authorized Representative)

_____
Relationship to Patient