RELEASE OF MENTAL HEALTH INFORMATION AUTHORIZATION

Acorn Counseling PLLC, 109 Enterprise Parkway, Suite 201, Boerne TX 78006, 830.981.5330 fax 830.755.5345

I hereby authorize Susan Loveland, MA, LPC, to disclose the individually identifiable health information as described below, which may include psychotherapy notes. I understand that this authorization is voluntary, and I may refuse to sign this authorization. I further understand that my heath care and the payment for my heath care will not be affected if I do not sign this form. I also understand that if I do not sign this form, federal and state law will prohibit Susan Loveland, MA, LPC, from releasing records regarding her treatment of me/my child to the designated Recipient.

I understand that if the recipient is authorized to receive the information is not a covered entity, e.g. insurance company or health care provider, the released information may no longer be protected by federal and state privacy regulations.

_____

Print Patient Name Date of Birth Social Security Number

Date(s) of service (if known): _____

Description of information to be released: (check all that apply)

_____ Entire Record _____ Evaluation Reports _____ Lethal Means Restriction
_____ Billing Records _____ Treatment Team _____ Progress Notes
_____ Emergency Contact

Description of the purpose of the use and/or disclosure and what will not be disclosed: _____
_____

The individually identifiable health information described herein shall be released to:

_____

NAME/RELATIONSHIP/ADDRESS/PHONE NUMBER(S) OF DESIGNATED RECIPIENT

I intend for this Authorization to remain in full force and effect until I revoke it in writing. Further, it is my intent that a copy of this Authorization shall have the same effect as the original.

I further understand that I may revoke this authorization at any time by notifying Susan Loveland, MA, LPC, in writing at Acorn Counseling PLLC, 109 Enterprise Parkway Suite 201, Boerne TX 78006. I also understand that the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

_____ _____

Signature of Client or Client's Representative Date

_____

Printed Name of Client or Client's Representative/Relationship to Client