Double Talk Therapy, PLLC

Therapy Office Location: 230 East Hunt Street, Suite 103B McKinney, TX 75069
Phone: (972) 332-0084 Fax: (972) 302-9141 Doubletalktherapy.com

info@doubletalktherapy.com

HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Medical records cannot be released until this form is completed and signed by the patient or legal guardian.
You must complete this form thoroughly.

PLEASE PRINT

Patient Name:		Date of Birth:
Address:		
City:	State:	Zip:

I hereby authorize Double Talk Therapy, PLLC to	Release: ☐	Obtain: ☐

From:	
Describe Information to be released or Obtained: ☐ All Speech & Language records ☐ All Dental Records	
☐ Continuity of Care	☐ Transfer of Care

CONDITIONS OF AUTHORIZATION

I may revoke this authorization in writing. If I do, it will not affect any previous actions already taken in reliance upon my authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. I may revoke this authorization by writing a letter and mailing it certified mail, return receipt requested, to the Privacy Officer at the healthcare provider listed above.
Information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer protected by Federal privacy regulations.

This authorization is valid for 1 year for the release of information as indicated above. **Only records from this facility can legally be released.** Any records from other physicians must be obtained from them.

Patient/Parent/Guardian Signature & Date:	
Witness Signature & Date:	

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THE INFORMATION. PLEASE REVIEW CAREFULLY:

I am required by the Health Insurance Portability & Accountability Act of 1996 (HIPAA) to provide confidentiality for all medical/mental health records and other individually identifiable health information in my possession. This Notice is to inform you of the uses and disclosures of confidential information that may be made by Double Talk Therapy, and of your individual rights and Double Talk Therapy's legal duties with respect to confidential information.

Ways in which I may use and disclose your protected Health information:

I may use and disclose at my discretion your medical records for each of the following purposes only: treatment, payment and health care operations.

- **Treatment** means providing, coordinating or managing mental health care and related services.
- **Payment** means activities such as obtaining payment for the mental health care services I provide for you from your insurance or another third-party payer.
- **Health care operations** include the business aspects of running a practice.

I may contact you to provide appointment reminders or other services that may be of interest to you. I will disclose your protected health information to any person you identify that is involved in payment for your care.

I will use and disclose your protected health information when required by federal, state or local law. There are certain situations in which as a therapist I am required by ethical standards to reveal information obtained during therapy to persons or agencies even if you do not give permission. These situations are as follows: (a) If you threaten grave bodily harm or death to yourself or another person, I am required by ethical standards to inform the intended victim and/or appropriate law enforcement agencies; (b) if you report to me your knowledge of physical or sexual abuse of a minor child or of an elder (over 65) or any sexual conduct/contact with a minor, I am required by law to inform the appropriate child welfare or social agency which may then investigate the matter; (c) if I am required by a court of law (court order) to turn over records to the court or if I am ordered to testify regarding those records.

Any other uses and disclosures will be made only with your written authorization. You will be provided with an authorization form upon request. A separate form will be needed for each request for release of information. The authorization for release of records is valid until it expires or is revoked. You may revoke authorization in writing a I am required to honor and abide by that written request, except to the extent that we have already taken actions

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relying on your authorization.

Please sign to indicate you understand my operation's use of your information for treatment, payment and health care operations as stated above.

Signature below is only acknowledgement that you have received the notice of our Privacy Practices. If the patient refuses to sign the notice, this practice is not obligated to treat the patient.

Print Name:_____ Date:_____

Signature:_____