Nathaniel D. Smith,
Licensed Professional Counselor

Phone: (214) 205-0237
Email: nathaniel@nathanielsmithcounselor.com
Website: www.nathanielsmithcounselor.com

Authorization for Use and Disclosure of Protected Health Information

Patient Identification

Printed Name: _____ Date of Birth: _____

Address: _____ Telephone: _____

_____ SSN: _____

Information To Be Released – Covering the Periods of Health Care

From (date): _____ to (date): _____

From (date): _____ to (date): _____

Type of information to be released: Full and Complete Office Record maintained by Nathaniel Smith, LPC.

Purpose of Request

☐ Treatment or consultation ☐ At the request of the patient ☐ Billing or claims payment

☐ Other, (specify): _____

Who and Where to Send / Release Information

Name: _____

Address: _____

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release

I understand if my medical, therapy or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, and/or other sensitive information, I agree to its release.

Check One: ☐ **Yes** ☐ **No**

I understand if my medical, therapy or billing record contains information in reference to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment I agree to its release.

Check One: ☐ **Yes** ☐ **No**

Time Limit & Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to Nathaniel Smith, LPC at 811 S Central Expy, Suite 525, Richardson TX 75080. Unless revoked, this authorization will expire on the following date or event _____, or 180 days from date of signature, unless otherwise specified.

Re-disclosure

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act of 1996. Nathaniel Smith, his employees, officers and agents are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient or Personal Representative Who May Request Disclosure

I understand that I do not have to sign this authorization, and my treatment or payment for services will not be denied if I do not sign this form unless specified above under Purpose of Request. I can inspect or copy the protected health information to be used or disclosed.

I authorize Nathaniel Smith, LPC to use and disclose the protected health information specified above.

Signature: _____ Date: _____

Authority to Sign if not patient: _____

Identity of Requestor Verified via: ☐ **Photo ID** ☐ **Personal Knowledge** ☐ **Other, specify:** _____

Verified by: _____