



# Gilstrap & Associates

Counseling & Massage for Children, Adolescents, Adults & Families

Dear Client,

Please find attached a copy of our **Notice of Privacy Practices**. This is in compliance with the **Health Insurance Portability & Accountability Act of 1996 (HIPAA)**. This Federal law requires that all health care professionals notify patients of how their health information is protected and how it may be used.

Florida law regarding psychotherapy is much stricter than Federal guidelines. HIPAA allows stricter state laws to prevail where conflict between the two may exist.

Please review the attached document and complete and sign the **Acknowledgement of Receipt of Privacy Practices**.

If you have any questions regarding HIPAA or our privacy practices, please contact us or discuss it with your therapist.

Thank you for your cooperation in this matter.

Sincerely,

Jessica M Gilstrap, MA, LMHC

Founder and Owner of Gilstrap & Associates

## Notice of Privacy Practices for Gilstrap & Associates

As of January 2012

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

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information “protected health information” used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. Examples of treatment would include psychotherapy, medication management, etc.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be billing your insurance company for your services, or third party person responsible.
- **Health Care Operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would include a periodic assessment of our documentation protocols, etc.

In addition, your confidential information may be used to remind you of an appointment (by phone or mail) or provide you with information about treatment options or other health-related services. We will use and disclose your PROTECTED HEALTH INFORMATION when we are required to do so by federal, state or local law. We may disclose your PROTECTED HEALTH INFORMATION to public health authorities that are authorized by law to collect information; to a health oversight agency for activities authorized by law included but not limited to: response to a court or administrative order, if you are involved in a lawsuit or similar proceeding; response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. We may release your PROTECTED HEALTH INFORMATION to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. We may use and disclose your PROTECTED HEALTH INFORMATION when necessary to reduce or prevent serious threat to your health and safety or the health and safety of another individual or to the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have certain rights in regards to your PROTECTED HEALTH INFORMATION, which you can exercise by presenting a written request to our Privacy Officer at the practice address listed below:

- The right to request restrictions on certain uses and disclosures of PROTECTED HEALTH INFORMATION, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to request to receive confidential communications of PROTECTED HEALTH INFORMATION from us by alternative means or at alternative locations.
- The right to request an amendment to your PROTECTED HEALTH INFORMATION.
- The right to receive an accounting of disclosures of PROTECTED HEALTH INFORMATION outside of treatment, payment and health care operations
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your PROTECTED HEALTH INFORMATION and to provide you with notice of our legal duties and privacy practices with respect to PROTECTED HEALTH INFORMATION.

We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all PROTECTED HEALTH INFORMATION that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office.

You have the right to file a formal, written complaint with us at the address below, or with the Department of Health and Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

**For more information about our Privacy Practices, please contact:**

Jessica M Gilstrap, MA, LMHC

7601 Conroy Windermere Road Suite 202

Orlando, FL 32835

407-522-9919

**For more information about HIPAA or to file a complaint:**

The U.S. Department of Health & Human Services

Office of Civil Rights

200 Independence Avenue, S.W.

Washington, D.C. 20201

877-696-6775 (toll-free)

Acknowledgment of Receipt of Privacy Practices for Gilstrap and Associates

As of January 2012

I, \_\_\_\_\_ have received a copy of Gilstrap and Associates Notice of Privacy Practices with an effective date of January 1, 2012.

**Print Name of Client:** \_\_\_\_\_

**Address of Client:** \_\_\_\_\_

\_\_\_\_\_

**Signature of Adult Client**

\_\_\_\_\_ **Date:** \_\_\_\_\_

**Signature of Guardian of Minor Client**

\_\_\_\_\_ **Date:** \_\_\_\_\_

**Name of Witness**

\_\_\_\_\_

**Signature of Witness**

\_\_\_\_\_ **Date:** \_\_\_\_\_

# PLEASE READ CAREFULLY AND SIGN

## LEGAL INVOLVEMENT

If your visit to our office will require our involvement in a legal process, i.e. deposition, court ordered evaluation, court appearance, or the like, we cannot guarantee confidentiality. Although we will follow all statutory obligations to honor your privacy and your confidentiality, the court can order our disclosure under specific circumstances beyond our control. Please consult with your attorney prior to your first session if you believe our services will involve the legal system.

ALSO, please be aware that our fees for involvement in the legal process are \$300.00 per hour, with a one (1) hour minimum. The legal process is time intensive and often requires us to cancel or reschedule appointments with other clients. In order to recoup our expenses for legal processes, we must charge these additional fees. Your account must be current prior to our involvement.

If the client is a minor the individual signed below will be responsible for the fees incurred as a result of legal proceedings. If the individual signing is not the minor's parent(s) or legal guardian, we must have legal documentation or responsibility on file prior to our first session with the child.

The fees for our involvement in the legal process are neither billable nor reimbursed by your insurance carrier. All fees are your responsibility and are payable in advance. We will not balance bill third parties or attorneys. We will accept cash, check, or credit card for our fees. We must have a valid credit card number on file. A form for this purpose is attached at the end of this intake package for your convenience.

We are not attorneys. For information of a legal nature please consult and follow the advice of a competent attorney. If your attorney requests information regarding your sessions with us, you will need to execute a signed written waiver of confidentiality. Please note that Jessica Gilstrap is professionally trained in Collaborative Family Law. Fees for reports, consultations, or recommendations are your responsibility and are billed at the \$300.00 fee mentioned above. A total breakdown of our Legal Billing Fees can be further explained if applicable to you.

As in all legal proceedings, final disposition is the responsibility of the court.

**I have read the above Legal Involvement and agree to its terms**

**Client Name**

\_\_\_\_\_

**Signature of Responsible Party**

\_\_\_\_\_ **Date:** \_\_\_\_\_

**Print Name**

\_\_\_\_\_

# Financial Policy for Gilstrap and Associates

Thank you for choosing us as your mental health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment. All clients must complete our Intake form before the first session.

## FULL PAYMENT IS DUE AT TIME OF SERVICE.

## WE ACCEPT CASH, CHECK, VISA, MASTER CARD, AND DISCOVER

### Regarding Indemnity Insurance

Your insurance policy is a contract between you and your insurance company. All insurance contracts are different depending on employer benefits, deductible amounts, co-pays, and etc. In order to keep our fees as low as possible, it is not possible for us to hire an insurance manager to determine what benefits your insurance may pay toward your treatment. What we can offer you is a SuperBill Receipt of your total payment with a diagnostic code located on it after your therapist has determined one, for you to submit to your Insurance Company for their reimbursement to you. Please inform us immediately if this option is what you would like to do so that we can note it on your account.

### Usual and Customary Rates

Our practice is committed to providing the best mental health treatment for our clients and we charge what is usual and customary for our area. You are responsible for payment regardless of any arbitrary determination of usual and customary rates imposed by your insurance company.

### Minor Clients

The adults accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, treatment will be denied unless charges have been pre-authorized to an approved credit card or payment by cash or check has been received by the time service is rendered.

### Third Party Payors

Any arrangements to have your bill paid by someone other than the responsible person signed below must be approved in writing prior to any services being provided.

### Missed Appointments/Financial Responsibility

Unless cancelled at least 24 hours in advance, our policy is to charge for your missed appointment at **\$75.00**. If there is no cancellation and you do not show up for your appointment, our policy is to charge for the total amount of the office visit. Please help us serve you better by keeping scheduled appointments.

Please make checks payable to **Heartspoken Counseling**. There will be a \$50.00 fee for checks that are returned as non-sufficient funds or non-payable.

I have read the Financial Policy. I understand and agree to this Financial Policy:

### Signature of Client or Responsible Party

\_\_\_\_\_ **Date:** \_\_\_\_\_

### Signature of Co-Responsible Party

\_\_\_\_\_ **Date:** \_\_\_\_\_

# Current Fee Structure for Gilstrap and Associates

As of January 2012

## **THIS FORM MUST BE SIGNED PRIOR TO THE FIRST SESSION**

**\*BY SIGNING THIS AGREEMENT, I ACCEPT RESPONSIBILITY TO PAY THESE FEES AS SERVICES ARE RENDERED. I FURTHER RECOGNIZE AND AGREE THAT SHOULD COLLECTION PROCEEDINGS BE NECESSARY UPON MY DEFAULT, I WILL BE RESPONSIBLE FOR ANY LEGAL FEES INCURRED AS A RESULT OF SUCH PROCEEDINGS. \***

IF YOU NEED TO MAKE SPECIAL ARRANGEMENTS FOR PAYING FOR OUR SERVICES, PLEASE SPEAK TO OUR OFFICE MANAGER AT THIS TIME. IF SPECIAL ARRANGEMENTS ARE MADE, THEY WILL BE INCLUDED WITH THIS SIGNED AGREEMENT AND WILL BECOME PART OF THE COUNSELING RELATIONSHIP.

**IF YOU HAVE MADE ARRANGEMENTS FOR SOME OTHER THIRD PARTY TO PAY FOR YOUR SERVICES, WE MUST HAVE THEIR SIGNED AGREEMENT ON FILE PRIOR TO YOUR FIRST SESSION.**

Initial Intake Interview.....	\$ 185.00
50 Minute Individual Session.....	\$ 125.00
50 Minute Joint Session.....	\$ 125.00
Two (2) Hour Session.....	\$ 250.00
Involvement in the legal process (one hour min.).....	\$ 300.00

Includes depositions, appearances, and evaluations

If you believe your insurance may reimburse you for your visits, please present us with the appropriate insurance information and allow us to keep a paper copy or your insurance card. We will provide you with any information necessary to assist you in gaining reimbursement.

### **Please Note:**

**In the event that your insurance company fails to reimburse for counseling services for any reason, or determines that agreed upon fees are the patient's responsibility you will be responsible.**

"I have read the above fee schedule and agree to its terms and conditions. I also have the right to a copy of this agreement upon request"

**Signature of Person Responsible for Payment**

\_\_\_\_\_ **Date:** \_\_\_\_\_

**Driver's License Number and State**

\_\_\_\_\_

**Print Name of Above Individual**

**Social Security Number**

\_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

<b>Office Use Only: (Special Arrangements)</b>
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## Mandatory Credit Authorization for Gilstrap and Associates

(If you do not have an approved credit card, please discuss this with the Office Staff)

Dear Patient,

By signing this form, you agree that any balance due will be charged to your credit card. If you have requested we provide you with the proper documentation for submission to your insurance company, we shall do so.

*The Agreed maximum amount to be charged to your credit card for the counseling service provided today is:*

***\$125.00 Per hour***

***(\$185.00 Per Initial Intake Interview)***

Please note, your credit card information will be kept confidential and secure. You have the option to receive a receipt from our office reflecting the charges applied to your credit card. Charges will appear on your credit card statement under the name HeartSpoken Counseling Inc. Please note, that any card ran through our system as a Credit Card, will have a \$2.00 service charge applied.

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By signing this form, I certify that this is my credit card and that I am legally authorized to give permission for its use. My signature further authorizes Gilstrap and Associates/HeartSpoken Counseling Inc to charge my credit card an amount not to exceed the "agreed maximum amount" referenced above. I understand that I may incur additional charges if my card is declined. I will notify Gilstrap and Associates of any changes to my account.

This authorization will remain in effect for one (1) year unless I cancel it through written notice to Gilstrap and Associates.

**Cardholder's Signature**

**Date**

\_\_\_\_\_

Patient Name: _____
Cardholder Name: _____
Cardholder Billing Address: _____
City _____ State _____ Zip _____
____ Visa      ____ Master Card      ____ Discover
Card Number: _____ Exp Date: _____
Code: _____ Billing Zip Code: _____

## Individual Client Information Questionnaire

**Date:** \_\_\_\_\_

Your cooperation in completing this questionnaire will be helpful in planning our services for you. Please answer each item carefully and completely. You may ask your therapist for clarification if you so desire. **If the client is a minor, please complete the intake packet on behalf of the child.**

CLIENTS FULL NAME: \_\_\_\_\_ AGE: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_\_

IF MINOR- LEGAL GUARDIAN'S FULL NAME: \_\_\_\_\_

CLIENTS MAILING ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PRIMARY PHONE: \_\_\_\_\_ OTHER PHONE: \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_

If necessary may we leave a message at your primary phone number?     Yes     No

RESPONSIBLE PERSON'S ADDRESS IF DIFFERENT FROM ABOVE: \_\_\_\_\_

CLIENTS SOCIAL SECURITY NUMBER: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ MARITAL STATUS: \_\_\_\_\_ SEX: \_\_\_\_\_

CLIENTS OCCUPATION: \_\_\_\_\_ IF STUDENT, SCHOOL: \_\_\_\_\_

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? \_\_\_\_\_

- WE LIKE TO SHOW OUR APPRECIATION TO REFERRAL SOURCES. IF YOU WERE REFERRED TO US BY A FRIEND, OR ANOTHER PROFESSIONAL, MAY WE CONTACT THEM TO EXPRESS OUR APPRECIATION?

\_\_\_\_\_ YES NAME AND PHONE NUMBER/ADDRESS: \_\_\_\_\_

\_\_\_\_\_ NO

WHEN WAS CLIENT LAST SEEN BY A PHYSICIAN? \_\_\_\_\_ PCP: \_\_\_\_\_

LIST ANY HEALTH PROBLEMS FOR WHICH THE CLIENT IS CURRENTLY RECEIVING TREATMENT:

LIST ALL MEDICATIONS CURRENTLY BEING TAKEN BY CLIENT: \_\_\_\_\_

HAS CLIENT EVER RECEIVED PSYCHOLOGICAL OR PSYCHIATRIC ASSISTANCE INCLUDING ANY TYPE OF COUNSELING? IF SO, PLEASE EXPLAIN WHEN AND WITH WHOM: \_\_\_\_\_

PLEASE EXPLAIN WHY YOU ARE SEEKING OUR ASSISTANCE: \_\_\_\_\_

WHEN DID YOUR PROBLEM(S) BEGIN? GIVE DATES AS BEST AS YOU CAN REMEMBER:

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PRESENTING PROBLEM: STATE IN YOUR OWN WORDS THE NATURE OF THE ISSUE(S) WHICH BROUGHT YOU TO COUNSELING:

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NAMES OF YOUR CHILDREN:

\_\_\_\_\_ DOB \_\_\_\_\_ SEX \_\_\_\_\_

\_\_\_\_\_ DOB \_\_\_\_\_ SEX \_\_\_\_\_

\_\_\_\_\_ DOB \_\_\_\_\_ SEX \_\_\_\_\_

ILLEGAL DRUG USE? \_\_\_\_ YES \_\_\_\_ NO

IF SO, WHEN, WHAT, AND HOW MUCH? \_\_\_\_\_

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**FAMILY INFORMATION:**

PARENTS: MOTHER: \_\_\_\_\_ FATHER: \_\_\_\_\_

ARE PARENTS ALIVE: \_\_\_\_\_

BROTHER/SISTER: \_\_\_\_\_ AGE: \_\_\_\_\_

BROTHER/ SISTER: \_\_\_\_\_ AGE: \_\_\_\_\_

BROTHER/SISTER: \_\_\_\_\_ AGE: \_\_\_\_\_

**RELIGION:**

WHAT CHURCH WERE YOU RAISED IN, IF ANY? \_\_\_\_\_

WHAT CHURCH DO YOU CURRENTLY ATTEND, IF ANY? \_\_\_\_\_

**ANY OTHER INFORMATION YOU WISH TO SHARE AT THIS TIME:**

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**CIRCLE ANY OF THE FOLLOWING EMOTIONS OR BEHAVIORS WHICH MAY PERTAIN TO THE CLIENT:**

AGGRESSIVENESS	DEPRESSION	LONELY	SELF-CONTROL
ALCOHOL USE	DIVORCE	LOSS	SEPARATION
AMBITION	DRUG USE	MARRIAGE	SEXUAL PROBLEMS
ANGER	ENERGETIC	MEMORY	SLEEP
ANNOYED	ENERGY	NERVOUSNESS	SMOKING
ANXIOUS	FEARS	NIGHTMARES/TERRORS	STRESS
APPETITE	FINANCES	ODD BEHAVIOR	SUICIDAL THOUGHTS
BORED	FRIENDS	OTHER PHYSICAL	TEMPER
BOWEL TROUBLES	GUILTY	PAIN	UNHAPPINESS
CAREER CHOICES	HEADACHES	PANICKY	VOMITING
CHILDREN	INFERIORITY	PARENTING	WITHDRAWL FROM PEOPLE
CONCENTRATION	INSOMNIA	REGRETFUL	WORK
CONFUSED	JEALOUS	RELATIONSHIPS	WORKS TOO HARD
CRYING	LAZY	RESTLESS	
DAY DREAMING	LEGAL MATTERS	SAD	
DECISION MAKING	LONELINESS	SELF MUTILATION	

**PLEASE READ THE FOLLOWING COUNSELING AGREEMENT AND SIGN. IF THE CLIENT IS UNDER 18 YEARS OF AGE, THE AGREEMENT MUST BE SIGNED BY THEIR PARENT OR GUARDIAN.**

“I understand that I am entering into a confidential therapeutic counseling relationship. I understand that I have the right to terminate this relationship upon due notice to my therapist.”

I also understand that ALL fees, as outlined on a separate attached and signed sheet, are due at the time services are rendered unless previous arrangements have been made. I UNDERSTAND THAT FAILURE TO CANCEL A SCHEDULED APPOINTMENT 24 HOURS IN ADVANCE WILL RESULT IN ME BEING CHARGED THE INFORMED AMOUNT FOR THAT SESSION.

I understand that my therapist has the right to consult with other therapists within the association related to my services and care. Information concerning my treatment cannot be divulged to other parties without my prior written consent unless directed by Florida Law. Other conditions of confidentiality will be discussed during the initial session.

I understand this agreement covers myself and any minor children I may include in therapy.

**Client Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Parent or Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**PLEASE ENSURE THAT ALL PAGES ARE READ AND SIGNED! THANK YOU!**

**\*\*PLEASE COMPLETE THIS PAGE ONLY IN CASES WHERE A MINOR CHILD DOES NOT LIVE WITH BOTH LEGAL/BIOLOGICAL PARENTS\*\***

**Parents Information:**

**PRIMARY RESIDENCE OF THE MINOR CHILD:**

\_\_\_\_\_

MOTHER OR FATHER NAME

\_\_\_\_\_

ADDRESS/CITY/STATE/ZIP

\_\_\_\_\_

TELEPHONE NUMBER

S M D W: MARITAL STATUS

EMAIL ADDRESS

**SECONDARY RESIDENCE OF THE MINOR CHILD:**

\_\_\_\_\_

MOTHER OR FATHER NAME

\_\_\_\_\_

ADDRESS/CITY/STATE/ZIP

\_\_\_\_\_

TELEPHONE NUMBER

S M D W: MARITAL STATUS

EMAIL ADDRESS

Document type that determined living arrangements of minor child (e.g. divorce, decree):

Describe the arrangement for seeking medical services on behalf of the minor child:

**\*\*Please be aware that this office will be contacting the other parent via US Mail if both parties are not present during the initial intake session\*\***

**\*\* Documentation may be requested to assure accurate arrangements for minor child\*\***



## Patient Right and HIPAA Authorizations

(Page 1 of 2)

The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time (“HIPAA”)

1. Tell your mental health professional if you don't understand this authorization, and they will explain it to you
2. You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to your mental health professional and your insurance company, if applicable.
3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment, make payment, or affect your eligibility for benefits. If you refuse to sign this authorization, and you are in a research-related treatment program, or have authorized your provider to disclose information about you to a third-party, your provider has the right to decide not to treat you or accept you as a client in their practice.
4. Once the authorization about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA.
5. If this office initiated this authorization, you must receive a copy of the signed authorization.
6. **Special Instructions for completing this authorization for the use and disclosure of Psychotherapy Notes.** HIPAA provides special protections to certain medical records known as “Psychotherapy Notes”. All Psychotherapy Notes recorded on any medium (i.e., paper, electronic) by a mental health professional (such as a psychologist or psychiatrist) must be kept by the author and filed separate from the rest of the client's medical records to maintain a higher standard of protection. “Psychotherapy Notes” are defined under HIPAA as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separate from the rest of the following: (a) medication prescription and monitoring, (b) counseling session start and stop times, (c) the modalities and frequencies of treatment furnished, (d) the results of clinical tests, and (e) any summary of: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

In order for a medical provider to release “Psychotherapy Notes” to a third party, the client who is the subject of the Psychotherapy Notes must sign this authorization to specifically allow for the release of Psychotherapy Notes. Such authorization must be separate from an authorization to release other medical records.



# Gilstrap & Associates

Counseling & Massage for Children, Adolescents, Adults & Families

## AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PAGE 2 OF 2)

1. Client's Name: \_\_\_\_\_  
Last Middle First

2. Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

3. Date Authorization Initiated: \_\_\_\_/\_\_\_\_/\_\_\_\_

4. Authorization Initiated By: \_\_\_\_\_  
Name (client, provider, or other)

5. Information to be released:

Authorization for Psychotherapy Note ONLY (Important: If this authorization is for Psychotherapy Notes, you must not use it as an authorization for any other type of protected health information.)

Other (describe information in detail): \_\_\_\_\_

6. Purpose of Disclosure: The reason I am authorizing release is:

My Request

Other (describe): \_\_\_\_\_

7. I authorize this person or organization (name and address)

To release / obtain the following information to / from:

Jessica Gilstrap, LMHC

Dara Champion, IMHC

Gregory Walker, IMHC

Christy Braman, LMHC

Tracy Valigdan, IMHC

Crystal Hollenbeck, IMHC

Brandon Gantt, IMHC

Brenda Stutler, IMHC

Brooke Maroth, SI

Phil Thompson, SI

Jessica Cloud, LMT

Karen Robertson, SI

8. This Authorization will expire on \_\_\_\_/\_\_\_\_/\_\_\_\_, or upon the happening of the following event:

\_\_\_\_\_

**Authorization and Signature:** I authorize the release of my confidential protected health information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected health information.

**Signature of the Patient:** \_\_\_\_\_

**Signature of Personal Representative:** \_\_\_\_\_

**Relationship to Patient of Personal Representative:** \_\_\_\_\_

**Date of Signature:** \_\_\_\_\_