

# **Authorization for Release of Protected Health Information**

**The Well Counseling & Consultation PLLC**

## **Client Legal Name**

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## **Authorization**

I authorize:

Jason Williamson MS

LPC Associate

LCDC I

The Well Counseling & Consultation PLLC

Supervised by Anita McNew LPC S Supervisor Number 64196

to release or obtain the following protected health information:

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## **To or From the Following Provider or Entity**

Provider Name

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Phone Number

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Relationship to Client

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## **Purpose of Disclosure (Initial all that apply)**

Continuity of care

- Treatment planning
- Legal or administrative purposes
- Personal records
- Insurance or billing
- Other \_\_\_\_\_

### **Confidentiality Statement**

I understand that my protected health information may be subject to disclosure under federal and state law, including the Health Insurance Portability and Accountability Act and applicable Texas Health and Safety Code provisions. \_\_\_\_\_

I understand that once this information is released, it may no longer be protected if the recipient is not a covered health care provider or entity. \_\_\_\_\_

I understand that this authorization is voluntary and may be revoked at any time by written notice, except where action has already been taken. This authorization will automatically expire one year from the date of signature unless otherwise revoked. \_\_\_\_\_

I understand that I have the right to receive a copy of this authorization. \_\_\_\_\_

I understand that I have the right to refuse to sign this authorization and that refusal will not affect my ability to receive treatment, except as required by law. \_\_\_\_\_

### **Texas Records Access and House Bill 4224 Notice**

In accordance with Texas Health and Safety Code Section 181.105 and House Bill 4224, clients have the right to request access to or copies of their health care records. Requests must be submitted in writing and may be subject to reasonable processing time and allowable fees under Texas law. Records will be provided within the time frames required by state and federal regulations unless access is restricted by law.

If you are a legal guardian or court appointed representative, documentation verifying your authority must be attached to this authorization.

### **Signatures**

Client or Legal Representative Signature

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Date

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Witness Name Printed

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Witness Signature

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Witness Date

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