Karma Counseling
Zahra Payravian, LPC

AUTHORIZATION TO RELEASE/EXCHANGE INFORMATION

Name of Client | Date of Birth

I,_____, hereby authorize Therapy Changes (hereinafter "Provider") to disclose/exchange mental health treatment information and records obtained in the course ofpsychotherapy treatment, including, but not limited to therapist's diagnosis, of the client listed above to:

Name | Phone

Address | Fax

City | State | Zip

I am requesting this disclosure of information and records for the following purpose:

☐ At the request of the individual ☐ Other: _____

The specific uses and limitations of the types of health information to be released are as follows:
(Check all that apply)

☐ Treatment
☐ CoordinationTreatment Planning
☐ Diagnostic Refinement
☐ Other: _____

Such disclosures shall be limited to the following specific types of information:

☐ Psychiatric diagnosis(es)Dates of Treatment Treatment Summary
☐ Initial Treatment Plan
☐ Full Treatment Record
☐ Other: _____

This authorization shall remain valid until:_____(not to exceed one year)

I understand that I have a right to receive a copy of this authorization. I understand that any cancellation ormodification of this authorization must be in writing. I understand that I have the right to revoke this authorization at any time unless Provider has taken action in reliance upon it. And, I also understand that such revocation must be in writing and received by Provider to be effective.

Provider shall not condition treatment upon my signing this authorization and I have the right to refuse to sign this form. I understand that information used or disclosed pursuant to this authorization may be subjectto re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule, although applicable Texas law may protect such information.

Signature of Client | Date

Signature of Legal Guardian, Relationship to Client | Date