Hickson's By Sammi
Office of Samuel Hickson, Ph.D., LCSW, NPT-C
Individual, Couples & Family Therapy: Teen to Adult
Web: https://www.hicksonsbysammi.com/

Authorization and Disclosure of Information

Client Name:_____ DOB:_____ SSN:_____

I,_____, authorize the information specified below to be disclosed as follows:

☐ FROM ☐ TO Hickson's By Sammi
PHONE (702) 265-7427 EMAIL: sammiscorner@gmail.com

NAME / ORGANIZATION: _____
☐ FROM ☐ TO ADDRESS: _____
PHONE/FAX/EMAIL: _____

Disclosure shall be limited to the following specific information contained in Client's records and/or obtained during the course of Client's diagnosis and treatment by Hickson's By Sammi:

	YES	NO		YES	NO
Assessment & diagnostic summaries	☐	☐	Billing payment records	☐	☐
Attendance record	☐	☐	Progress reports	☐	☐
Treatment goals	☐	☐	Discharge summary	☐	☐
Treatment plan	☐	☐	Verbal exchanges	☐	☐
Progress notes (specify dates below)	☐	☐	Other (specify below)	☐	☐

_____ _____

If information in Patient's records pertains to HIV/AIDS, I expressly DO / DO NOT authorize Hickson's By Sammi's office to disclose such information pursuant to this authorization. Circle N/A if not applicable.

I am requesting that this information be disclosed for the purpose(s) of:

_____

This authorization shall be in full force and effect until _____. If no expiration date is provided, this authorization shall expire 180 days after the date on which I signed below.

I am aware of the confidential and/or privileged nature of the information being disclosed and understand the benefits and/or disadvantages of disclosing such information. I hereby release Hickson's By Sammi and its affiliates, representatives and assigns from all legal liabilities that may result from the release of this information. I acknowledge that I have the right to revoke this authorization at any time by sending written notification to Hickson's By Sammi's office. I understand that a revocation is not effective if Hickson's By Sammi's office has already taken actions in reliance upon this authorization. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal and state privacy laws and regulations.

_____
Print Name of Client

_____ _____
Client/Responsible Party Signature For Responsible Party, indicate authority to sign

_____ _____
Witness Signature Date

Notice to Recipient: This authorization provides for a release of information about an individual whose confidentiality is protected by federal and state laws and regulations, including the Health Insurance Portability and Accountability Act of 1996 (45 CFR 160-164) as well as 42 CFR Part 2 and 42 USC 290dd-2 and state confidentiality laws. No information disclosed from this authorization may be re-disclosed without the specific written consent of the individual to whom such information pertains.