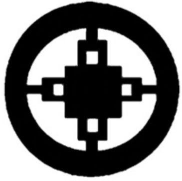

SEAN GORMAN LPC, P.C.
141 E. Mercer St. Suite D
Dripping Springs, TX 78620
Texas License: #74256

AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

AUTHORIZATION TO RELEASE INFORMATION TO AND FROM SEAN GORMAN

CLIENT NAME:____DOB:________________

I,____,
(Please print: First Name, Middle Initial and Last Name of person releasing/requesting records)

hereby authorize Sean Gorman to release/request the above named individual's health information to/from:
(Please print: Full name of person(s) you authorize to receive the information, their company/organization, mailing address and phone number.)

Name:____

Company/Organization:____

Mailing Address:____________________________________City/State/Zip:___________________

Phone Number: _____________________________________Fax Number: ______________________

The Following Protected Health Information may be released/requested as part of the documents you check below, including information about behavioral and mental health services, treatment for alcohol and drug abuse, and medical information:
Please check requested documents below:

__ Psychiatric Assessment
__ Discharge Summary
__ Progress Notes
__ Report Cards/Transcripts
__ Labs
__ Immunizations
__ History & Physical
__ Plan of Care (Tx Plan)
__Other____
__ Biopsychosocial Assessment
__ Individualized Education Plan (IEP)
__ Dental/Visual Consults

__Verbal Authorization for ______________________________ to speak with__________________________________

For the following purpose or purposes: **(if the individual initiates the authorization and does not want to provide a purpose, enter "at the request of the individual."):**
__ at the request of the individual
__ SSI Determination
__ sharing with other health care providers as needed
__ other (please describe):____

If not previously revoked, the authorization expires on the following date or event: **(If use or disclosure is for a one-time use or disclosure time, enter "One-time U&D"):**
Insert date or event: ____
__ 90 days after discharge from treatment

I understand that once the above information is disclosed, it may be redisclosed to the recipient and the information may not be protected by federal privacy laws or regulations.

Signed:____Date:_______________

Relationship to Client:______________________________Custodial Parent: Yes No (circle one)