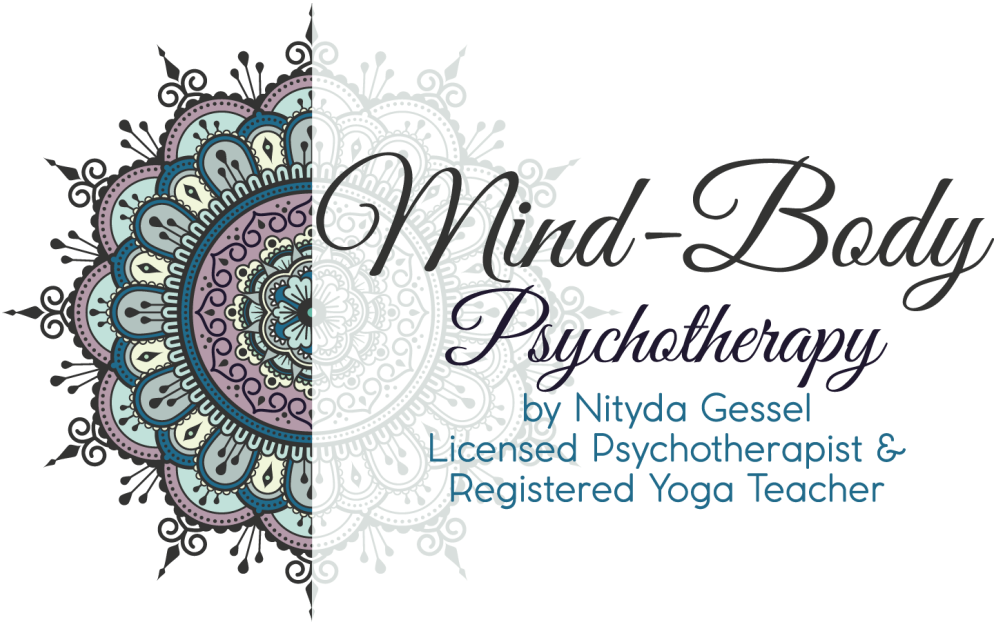

1823 Fortview Road, Suite 211, Austin, TX 78704 512.402.2650
www.talkwithnityda.com nityda@talkwithnityda.com

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Client Information:

Name _____DOB _____Age_____

Address_____

City _____State _____ Zip Code _____

I give permission for the following two agencies/persons to share (both send and receive) my protected health information as indicated below:

Name: Nityda Gessel, LCSW, E-RYT	AND	Name:
Address: 1823 Fortview Ave, Ste 211 Austin, TX 78704		Address:
Phone: 512.402.2650		Phone:

Please circle what information you are allowing to be released:

Dates/Times of Service Treatment Plan(s) Evaluation/Assessment

Progress Notes

Verbal Discussion of Case Diagnosis/Impressions Entire Case File

Other:_____
_____

I understand that my records are protected under Federal and State Laws and cannot be disclosed without a written consent, except as specifically stated by law. This request in entirely voluntary on my part. This authorization can be canceled at any time by request, in writing, but the cancellation will not affect any disclosure already made prior to receipt of cancellation notice. This office cannot control how the protected health information will be used/shared by the agency/person who receives it under this authorization. Unless cancelled or otherwise specified, this authorization will expire one year from date of signature.

Other Specified Expiration Date: _____

_____ _____
Client Signature Date

_____
Print Client's Name