New Client Intake Packet

Created by LaShaun N. Mwangi, M.A.,LPC

Envision Harmony Counseling, PLLC

Today's Date: _____/_____/_____

Name: _____ _____ _____
(First) (Middle) (Last)

Date of Birth : _____/_____/_____ Gender: _____
Email Address:_____
Home Address: _____
(Street Address) (Apartment Number)

_____ _____ _____
(City) (State) (Zip Code)

Phones
Home: ( ) _____ Cell: ( ) _____ Work: ( ) _____

Marital Status:
[ ] Married [ ] Single [ ] Separated
[ ] Divorced [ ] Widowed [ ] Domestic Partnership

Employment
[ ] Full-time [ ] Part-time [ ] Unemployed

Employer:
_____

Student Status: (if attending school):
[ ] Full- time [ ] Part-time

Who recommended us or referred you to this office?
[ ] Online search [ ] Friend/Family/Colleague [ ] EAP Referred
[ ] Insurance Directory [ ] Other (Please Specify) _____

Mail sent from this office (such as letters or bills) will bear the address of our facility. In order to protect your privacy, we will make special mailing arrangements if you specify below that you wish for us to do so. Otherwise, we will send mailings to you by using the mailing address listed above.

Any special contact arrangements we need to know about? If so, please explain:
_____
_____

Please list your concerns in order of their importance to you:

1. _____
2. _____
3. _____

Have you lost something of importance in the past two years? (e.g. spouse, pet, job, friend, health)

_____

_____

What are the names & ages of the other individuals living in your home with you?

Name	**Age**	**Relationship**

Do you have children not currently living with you?

Name	**Age**	**Relationship**

Please list any medications you are currently taking:

Name of Medication	**Purpose of Medication**	**Dosage**

Name of the Physician/Psychiatrist who is monitoring your medication:

Name:	
Address:	
Phone:	

If need be, are you willing to sign a release of information, in order to speak with your medical doctor? [ ] Yes [ ] No, not at this time.

Do you want this office to file to your Insurance/EAP? [ ] Yes [ ] No

INSURANCE - EAP - SELF PAY WORKSHEET

If you wish this office to file Insurance for you, please complete the following.

Subscriber's Name: (Name of Policyholder): _____

Insured's Home Address *(If different from client's*)

Street Address _____

City/State/ZipCode _____

Insured's Social Security Number: _____ - _____ - _____

Insured's Birthdate: MM/DAY/YEAR: _____/_____/_____

Insured's Home Phone: (_____) _____Cell:(_____)_____

Insured's Work Phone: (_____) _____

Client's Relationship to Insured: (e.g. spouse, child,): _____

Name of The Insured's Employer: _____

Insurance Company Name: _____

Phone Number to Verify Benefits: _____

Subscriber ID Number: _____ Group Number _____

****If You Will Be Using Your Employee Assistance Program Benefits, We Need:

Name of The EAP :_____

Phone Number: _____

Authorization Code: _____ Number Of Sessions: _____

Please be advised, your therapist will be required to disclose information regarding your care to your insurance company, managed care company, or employee assistance program if you wish him/her to file for benefits rather than accept full payment from you at the time services are rendered. Once the information is submitted, your therapist cannot guarantee it will be appropriately safeguarded by the company. Your therapist may be required to share with the company all information in his/her files, including case and progress notes.

I AM ELECTING TO USE THE SELF PAY OPTION.

Agreed Fee for 1 Hour Session: $_____.

Agreed Fee for 45 Minute Session: $_____.

Please Initial Here: _____

MESSAGING AUTHORIZATION

From time to time it is necessary for the therapist at Envision Harmony Counseling, PLLC to contact clients for various reasons and/or to leave a message. The usual purpose of a message is to remind clients that they have an appointment or to ask a client to call the office regarding an issue or concern.

At no time will Envision Harmony Counseling, PLLC discuss your case, circumstances or condition without your consent. The purpose of this form is to designate the method that is acceptable for contact and/or grant consent to leave messages with members of your household, or on your voice mail.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Please note: **Electronic communication** (Email or Texting), although intended only for the use of the individual or entity to which it is addressed, is not guaranteed to be secure. Please fill in requested information and initial each channel below through which you grant us permission to contact you.

Email:	You may contact me via email.	Initial: _____
SMS/Text:	You may send me sms/text messages.	Initial: _____
Voice Mail @ Home:	You may leave voice messages on my home phone.	Initial: _____
Voice Mail @ Mobile:	You may leave voice messages on my mobile phone.	Initial: _____
Voice Mail @ Work:	You may leave voice messages on my work phone.	Initial: _____

If someone other than you, the client, answers any the phones listed above, may we leave a message with that person?	[ ] Yes [ ] No	Initial: _____

Client Name(Print):_____

Client Signature: _____

Date: _____/_____/_____

GENERAL INFORMATION

Mental Health Services

While it may not be easy to seek help from a mental health professional, it is hoped that you will be better able to understand your situation and feelings in order to resolve the difficulties which prompted you to seek professional assistance. The therapist, using his or her knowledge of human development and behavior, will make observations about situations as well as suggestions for new ways to approach them. It will be important for you to explore your own feelings and thoughts and to try new approaches in order for change to occur. You may bring other family members to a therapy session if you feel it would be helpful or if this is recommended by your therapist.

Risks of Therapy

Therapy is the Greek word for change. You may learn things about yourself that you don't care for. Often, growth cannot occur until you experience and confront issues that induce you to feel sadness, sorrow, anxiety, or pain. One might hope this would balance out with the discovery of joy, relief and freedom as well. The success of our work together depends on the quality of your efforts and the realization that you are responsible for lifestyle choices or changes that may result from therapy.

Specifically, one risk of marital therapy is the possibility of exercising the divorce option.
Or another risk of individual therapy, is the possibility of developing a habit of overanalyzing yourself.

Therapy Plan

Your therapist is a licensed professional providing mental health care services as an independent contractor/provider for various insurance and Employee Assistance Program entities. You will be creating a treatment plan with your therapist in order to maximize your personal growth. The plan includes the number and frequency of session, type of session (individual, family/marital or group) and the scope of the process.

Counseling Relationship

Your relationship with any therapist is a professional and therapeutic one. It is imperative that your therapist does not have any other type of relationship with you. Personal and/or business endeavors undermine the effectiveness of the therapeutic relationship. Your therapist cares about helping you, but is not in a position to have a social, personal, or business relationship with you of any kind.

Please Initial Here: _____

PAYMENT FOR SERVICES

Payment is due at the time services are rendered.

If this office will be filing insurance for you, please be informed that verification of insurance benefits with your insurance carrier does not guarantee payment by your insurance company. Any remaining balance will be your responsibility and the therapist will look to you for full payment of your account. Different co-payments are required by various group coverage plans. In addition, the co-pay may be different for the first visit than for subsequent visits. Even though we verify your benefits, it is also recommended that you determine your co-payment/deductible by calling your benefits office or insurance company.

Additional Service Cost For Legal Venues
Although it is the goal of the undersigned therapist to protect the confidentiality of your records, there may be times when disclosure of your records or testimony will be compelled by law. Confidentiality and exceptions to confidentiality are discussed below. *In the event disclosure of your records or testimony is required by law, you will be responsible for and shall pay the costs involved in producing the records.* An addition fee of **$225 per hour** will be assigned for preparing and giving testimony, if being requested or mandated. Payments will need to be made prior to the time the services are rendered by the therapist. Typically, the therapist will charge a minimum of 3 hours payable in full, prior to any preparation. Insurance cannot be filed for these types of services.

Report Preparation Fees
*We **do not** fill out paperwork for FMLA, Short - Term Disability, Long - Term Disability, Workman's Compensation claims, or write letters for Emotional Support Animal requests.* When these types of requests are made, we can no longer guarantee your confidentiality will be upheld by your provider or Envision Harmony Counseling, PLLC.

These types of requests should be filled out specifically *by your medical doctor.* This paperwork requires a medical diagnosis from your medical doctor. Counseling services do not serve as a substitute, nor does it bypass medical care that is required, in order for these certain types of documents to be completed.

If we receive forms from you or an outside requestor, you essentially are requesting that your counselor prepare this for you. You will be assessed a fee of **$250.00** which is payable by you, *prior* to the request being completed.

Cancellation Fee

Therapy appointments are usually 45 minutes in length. Your therapy time is reserved for you. *Please call to cancel or reschedule at least 24 hours in advance*. If 24 hours notice is not given or a "no show" occurs, *you will be charged a customary* **$75.00** fee for the missed appointment. This is not covered by your EAP or insurance carrier.

Please Initial Here: _____

Emergency Calls

An emergency is an *"urgent" issue* that requires an *"immediate" action* of some kind. Occasionally, an emergency requires telephone counseling. Your therapist is on call 24 hours a day, seven days a week and may be reached by dialing the emergency number given on your his/her outgoing voice-mail message. Insurance does not cover charges for emergency telephone counseling. *The fee for the emergency call will be **$75.***

If you have anonymous call blocking, you will need to deactivate it to receive a return call from our therapist. If you cannot wait for a return call, please dial 911 or go to your local emergency room hospital.

Confidentiality

Confidentiality is defined as keeping private the information shared by you, the client, and your therapist. As a client, you have the right to withhold or release information to other individuals or agencies.

No information will be released to anyone not performing business for this office without your consent unless mandated by Texas law. You may request an accounting of all disclosures made of your records, and, whenever it is possible, any disclosure of your healthcare information to an outside individual or agency will be discussed with you prior to disclosure. Please be advised that, although protecting your confidentiality is a priority for your therapist, Texas law mandates several exceptions to your right to confidentiality.

Possible exceptions to confidentiality include but are not limited to the following situations:

Child abuse; abuse of the elderly or disabled; abuse of patients in mental health facilities; sexual exploitation; licensing board investigations; criminal prosecutions; child custody cases; lawsuits; situations where the therapist has a duty under the law to disclose, or where, in the therapist's judgement, it is necessary for safety to warn or disclose; fee disputes between the therapist and the client; or filing for insurance reimbursement.

If you have questions regarding confidentiality, you should bring them to the attention of your therapist and discuss this matter further. Please be advised that by signing this information and consent form, you are giving your consent to the undersigned therapist to share confidential information with all persons mandated by law, and you are releasing and holding harmless the undersigned therapist from any departure from your right of confidentiality that may result.

Please Initial Here:_____

Custodian of Your Records

Envision Harmony Counseling, PLLC is the custodian of your records. Should Envision Harmony Counseling, PLLC need to close the practice for an emergency requiring a prolonged or permanent absence, it may become necessary for your file to be passed to a new custodian for safekeeping.

You have the right to inspect, copy, or request your therapist amend the information maintained in your record. By signing this information and consent form, you are acknowledging that, in the event that the undersigned therapist becomes incapacitated or dies, it will become necessary for another therapist/entity to take possession of my file and records for safekeeping.

By signing this information and consent form you are giving your consent to allow another licensed mental health professional or entity, to take possession of your file and records. In this way, your records may be maintained and protected as confidential.

Consent To Treatment

I, voluntarily, agree to receive Mental Health assessment, care, treatment, and authorize the undersigned therapist to provide such care, treatment, or services as are considered necessary and advisable.

I understand and agree that I will participate in the planning of my care, treatment, or services, and that I may stop such care, treatment, or services that I receive through the undersigned therapist at any time.

By signing this Client Information and Consent form, I, the undersigned client, acknowledge that I have both read and understood all the terms and information contained herein. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

_____ _____

Client Signature Date

As witnessed by:

_____

Date _____ Therapist

INSURANCE/EAP INFORMATION

Because the filing of insurance/EAP claims necessitates your waiver of your right to confidentiality in this manner, it is recommended that you consider paying for mental health services yourself. By signing below, you are authorizing this office to file insurance claims for you and receive payment directly from your insurance carrier.

- I, the undersigned, on this date have requested that my therapist accept assignment of my insurance benefits for charges for mental health services rendered to me.
- I authorize payment of medical benefits directly to the supplier of services.
- I agree to sign any and all forms necessary for the submission of a claim for payment of benefits to my therapist by my insurance/EAP company.
- I hereby consent and authorize the undersigned therapist and his/her staff to provide my insurance/EAP company with any and all information requested by my insurance/EAP company in connection with its review and consideration of the claim for payment of benefits.
- I acknowledge that I am waiving my right to confidentiality with respect to the records and information requested by my insurance company or employee assistance program as well as the managed care company and/or insurance carrier responsible for providing my mental health care services and payment for those services.
- I understand that I may revoke this authorization at any time, in writing, and that such revocation will apply to my records except to the extent that action has been taken prior to such revocation in reliance on this authorization.
- I hereby release and hold harmless the undersigned therapist and his/her agents and staff from any and all liability arising from release of the information and records requested.

SIGNED this _____ day of month _____ , 20_____.

_____ _____ _____/_____/_____
Client Signature Social Security Number Date of Birth

WITNESSED BY:

_____
Therapist Signature

TECHNOLOGY

We need your help.

Keeping conversations confidential and secure between you and your therapist is important to us *no* other eyes or ears, are privy to the communication between you and your therapist. And because of this, we will be restricting all technological correspondence with you.

- **Even though you may have given us permission** to correspond via a regular email option, and/or text option, we cannot guaranty its security. Text messages are not secure for anyone. And, as a result, your Life Tree counselor will be limiting this type of communication with you.
- **If you need to contact your therapist,** you will either need to leave a message on his/her confidential voice mail, or you may email your counselor.
- As a cyberviolation precaution, **we will *not utilize*** any type of FaceTime or Skype with you, ***at any time, for any reason.***
-

Client Signature _____ Date_____

HIPPA - Notice of Privacy Policies

Client Name:_____ Date:_____

This notice describes how your private health information may be used and disclosed, and how you can gain access to this information. Please review it carefully.

Private Health Information may be used and disclosed in the following circumstances:

1. Information that is necessary in order for LTCC to file insurance claims and successfully complete all billing and collection procedures.
2. When required for public health issues such as workman's compensation.
3. When required by any state or federal law, including cases of abuse and neglect.
4. When required for any specialized government or military functions including active personnel, reservists, veterans, and discharged members of the military service. Also, for any person confined to a correctional institution or under any law enforcement supervision.
5. When used for any clerical purposes and necessary chart audits by managed care companies.
6. In accordance to Texas Health & Safety Code, Chapter 611, records of release protocol.

As a client, you have rights to your Private Health Information, including:

1. The right to review your records or receive a copy of your records at any time by signing a formalized, written request. However, under certain rare circumstances your request can be denied. Written requests for records will be honored within 15 days after receiving a proper written request has been filed with LTCC.
2. The right to request information of any party that has requested information pertaining to your Private Health Information.
3. The right to receive confidential information regarding your private health information.
4. The right to revoke this consent in writing; however, this will not affect any information already disclosed.

Please Initial Here: _____

HIPPA - NOTICE of PRIVACY (cont.)

Envision Harmony Counseling,
PLLC has the responsibility to:

1. Make you, the client, aware to review our LTCC Privacy Policies which is available upon request for you, at our office.
2. To make the necessary changes to the Privacy Notice that are required by law.
3. If you as the client feel your privacy has been violated, you have the right to contact The US Department of Health & Human Services Office of Civil Rights at www.hhs.gov/ocr/hipaa/.

Or, you may file a complaint to the Texas State Board of Examiners of Professional Counselors in Austin, Texas. The contact information is located in the office lobby.

I have reviewed and understand this notice.

Client : _____

Client Signature _____

Date of Birth:_____/_____/_____ Today's Date:_____/_____/_____

******SIGN BELOW IF A CHILD 18 YEARS AND UNDER:**

I*F THE MINOR CLIENT IS NAMED IN A CUSTODY AGREEMENT OR COURT ORDER, YOU SHALL GIVE THE TREATING PROVIDER A FULL COPY OF THE MOST RECENT CUSTODY AGREEMENT AND/OR COURT ORDER, AS WELL AS ANY DIVORCE DECREE.IT WILL BE MAINTAINED IN THE MINOR CLIENT'S FILE.*

IT IS THE RESPONSIBILITY OF THE PARENT TO PROVIDE ANY AND ALL UPDATED DOCUMENTS SHOULD IT OCCUR DURING THE TIME OF TREATMENT.

Minor Client Name:(under 18 years old):_____

Date of Birth:_____/_____/_____

Parent or Custodial Guardian Signature: _____

Relationship To The Client: _____

NONDISCRIMINATION STATEMENT

My agency complies with Title VI of Civil Rights Act of 1964, Section 504 of Rehabilitation Act of 1973, American Disability Act of 1990, and the Health and Safety Code relating to workplace and confidentiality guidelines regarding AIDS and HIV. Individuals will not be discriminated against based on sex, age, race, color, political beliefs, sexual orientation, national origin, religion, or physical disabilities.

I understand that due to the American for Disabilities Act requirements, I may not receive and/or ask client to notify me of have HIV and AIDS or any other protected illness or disability if you think you have been discriminated against, contact immediately:

Civil Rights Office
Health and Human Services Commission
701 W. 51st. Street, MC W206
Austin, Texas 78751
1-888-388-6332 or 1-512-438-4313
TTY toll-free:1-877-432-7232
HHSCivilRightsOffice@hhsc.state.tx.us

CLIENT COMPLAINTS

I strive to provide a safety and supportive environment during the therapy process. If a client feels they are being treated unfairly or in a less supportive manner, a client has a complaint about any licensed by the State of Texas to practice counseling, you may file your compliant with the appropriate licensing board,

Texas Behavioral Health Executive Counsel:
333 Guadalupe St. Ste. 3-900
Austin, TX 78701

LaShaun Mwangi, M. A. LPC, NCC

Envision Harmony Counseling, PLLC

214-307-2314

Policy Update

It is now the policy of Envision Harmony Counseling, PLLC to have ***zero tolerance policy*** *when it comes to clients being verbally abusive, threatening, or participating in any type of bullying, attacking, or harassing, type of behaviors. As of June 4, 2019, if a client tries to stalk the counselor using social media, following the, their car, waiting for them in a parking lot, contacting their friends or family members, or shows up in the vicinity of their residence, office, or a professional event, then that will be* ***grounds for immediate terminations with a possible filing of a police report****.*

As of June 4, 2019 if a client becomes ***verbally abusive****, as evidenced, but not limited to,* ***swearing, screaming, abusive comments, threats, derogatory, remarks, or unreasonable demands*** *to the counselor, then the client will receive a warning. However, if the client chooses to continue to be verbally abusive, then it is the counselor's prerogative to terminate counseling services as a way to protect herself from further abuse, liability issues, and to role model healthy boundary setting,*

As of June 4, 2019 if a client chooses to send ***multiple (defined as 3 or more, not including counselor's response), consecutive voice mails, texts, or emails within a 12 hour period, then fees will not only apply****, but if the counselor deems it as harassment, then the counselor will give a warning.* ***If the warning is not heeded****, then counselor invokes the* ***right to terminate counseling services****. If a client is that upset that they cannot control their emotions, then they should seek more intensive treatment.*

If client ***creates a "scene" in the waiting area or parking lot of the building****, then counselor has/have the right to ask the client to immediately leave the office and parking lot premises If the client* ***refuses****, then* ***the Dallas Police Department will be contacted an a report will be filed****. If the Police have to come out to the office,* ***then counseling services will be terminated*** *with the client unless extenuating circumstances are associated with the event.*

If the client harasses another client, that is immediate grounds for termination.

_____ _____

Client Signature ***Date***

_____ _____

Counselor Signature ***Date***

Envision Harmony Counseling, PLLC
AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION
Developed for Texas Health & Safety Code § 181.154(d)
Effective June 2013

This form was created by the **Texas Attorney General and amended by LaShaun Mwangi, M.A., LPC to reflect the specific needs of a counseling practice.*

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information. Covered entities as that term is defined by HIPAA and Texas Health & Safety Code § 181.001 must obtain a signed authorization from the individual or the individual's legally authorized representative to *electronically disclose* that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.

NAME OF PATIENT/CLIENT OR INDIVIDUAL:

_____
Last First Middle

DATE OF BIRTH: Month _____ Day _____ Year _____

ADDRESS: _____
CITY: _____ **STATE**: _____ **ZIP**: _____
PHONE: (_____) _____

I AUTHORIZE THE FOLLOWING PROFESSIONAL **TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:**

Person/Organization Name: __**LaShaun Mwangi, M.A., LPC, License 75274**_____
Address: 17740 Preston Rd, Suite 200-B___
City: Dallas___ State: Texas__ Zip: _75252_
Phone: (214) _307-2314__ Fax: (214) 594-6191___

WHO CAN ***RECEIVE*** AND **USE** THE HEALTH INFORMATION? (Counselor is sending information to whom?)

Person/Organization Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (_____) _____ Fax: (_____) _____

I authorize information to be transmitted through the following options: ___Fax ___Phone Call __E-mail ___Mail

REASON FOR DISCLOSURE (Choose **only one** option below):

_____ Treatment/Continuing Medical/Psychological Care _____ Personal Use _____ Billing or Claims

_____ Insurance _____ Legal Purposes _____ Disability Determination _____ School _____ Employment

_____ Other _____

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. **If *all* health information is to be released, then check only the first box.**

____ **All** health information ____ Intake/Psychosocial History ____ Past/Present Medications as stated by Client

____ Progress/Session Notes ____Discharge Summary ____Consultation Reports/Calls with other Providers/ Professionals

____ Billing Information (dates of service, amount paid, billing code, balance due)

____ Diagnostic Test Reports as given by a 3rd party (as Mrs. Mwangi does not administer Diagnostic Tests)

____ Written summaries that include symptoms, diagnosis, risk factors & risk history, medication concerns.

Your initials are required to release the following information:

_____ Mental Health Records _____ Drug, Alcohol, or Substance Abuse Records

EFFECTIVE TIME PERIOD: This authorization is valid until the earlier of the occurrence of death of the individual; the individual reaching the **age of maturity**; or permission is **withdrawn**; **or** the following **specific date** (1 year from today):

Month _____ Day _____ Year _____

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving the **written notice stating my intent to revoke this authorization** to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including
disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). 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 or state privacy laws.

SIGNATURE X_____ _____
Signature of Individual or Individual's Legally Authorized Representative **DATE**

Printed Name of Legally Authorized Representative (if applicable): _____

If Representative, specify relationship to the individual: ____Parent of Minor _____Guardian _____ Other
A **minor individual's signature is required for the release** of certain types of information, including for example, the release of information related to certain types of reproductive care, **sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment** (See, e.g., Tex. Fam. Code §32.003).

SIGNATURE X_____ _____
Signature of Minor Individual **DATE**

The Attorney General of Texas has adopted a standard Authorization to Disclose Protected Health Information in accordance with the Texas Health & Safety Code § 181.154(d). This form is intended for use in complying with the requirements of the Health Insurance Portability and Accountability Act and Privacy Standards (HIPAA) and the Texas Medical Privacy Act (Texas Health and Safety Code, Chapter 181). **Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.**

Covered entities, as that term is defined by HIPAA and Texas Health & Safety Code § 181.001, must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. (Tex. Health & Safety Code §§ 181.154(b), (c), § 241.153; 45 C.F.R. §§(a)(1); 164.506, and 164.508).

The authorization provided by use of the form means that the organization, entity or person authorized can disclose, communicate, or send the named individual's protected health information to the organization, entity or person identified on the form, including through the use of any electronic means.

Definitions – In the form, the terms "treatment," "healthcare operations," "psychotherapy notes," and "protected health information" are as defined in HIPAA (45 CFR 164.501). "Legally authorized representative" as used in the form includes any person authorized to act on behalf of another individual. (Tex. Occ. Code § 151.002(6); Tex. Health & Safety Code §§166.164, 241.151; and Tex. Probate Code § 3(aa)).

Health Information to be Released – If "All Health Information" is selected for the release, health information includes, but is not limited to, all records and other information regarding health history, treatment, hospitalization, tests, and outpatient care, and also educational records that may contain health information. As indicated on the form, specific authorization is required for the release of information about certain sensitive conditions, including:

- Mental health records
- Drug, alcohol, or substance abuse records.

Note on Release of Health Records – This form is not required for the permissible disclosure of an individual's protected health information to the individual or the individual's legally authorized representative. (45 C.F.R. §§ 164.502(a)(1)(i), 164.524; Tex. Health & Safety Code § 181.102). If requesting a copy of the individual's health records with this form, state and federal law allows such access, *unless such access is determined by the physician or mental health provider to be harmful to the individual's physical, mental or emotional health*. (Tex. Health & Safety Code §§ 181.102, 611.0045(b); Tex. Occ. Code § 159.066(a); 45 C.F.R. § 164.502(a)(1)). If a healthcare provider is specified in the "Who Can Receive and Use The Health Information" section of this form, then permission to receive protected health information also includes physicians, other health care providers (such as nurses and medical staff) who are involved in the individual's medical care at that entity's facility or that person's office, and health care providers who are covering or on call for the specified person or organization, and staff members or agents (such as business associates or qualified service organizations) who carry out activities and purposes permitted by law for that specified covered entity or person. If a covered entity other than a healthcare provider is specified, then permission to receive protected health information also includes that organization's staff or agents and subcontractors who carry out activities and purposes permitted by this form for that organization. Individuals may be entitled to restrict certain disclosures of protected health information related to services paid in full by the individual (45 C.F.R. § 164.522(a)(1)(vi)).

Authorizations for Sale or Marketing Purposes: Envision Harmony Counseling, PLLC will NEVER sell any client information (Tex. Health & Safety Code § 181.152, .153; 45 C.F.R. § 164.508(a)(3), (4)).

Limitations of this form – This authorization form shall not be used for the disclosure of any health information as it relates to: (1) health benefits plan enrollment and/or related enrollment determinations (45 C.F.R. § 164.508(b)(4)(ii), .508(c)(2)(ii); **Use of this form does not exempt any entity from compliance with applicable federal or state laws or regulations regarding access, use or disclosure of health information or other sensitive personal information (e.g., 42 CFR Part 2, restricting use of information pertaining to drug/alcohol abuse and treatment), and does not entitle an entity or its employees, agents or assigns to any limitation of liability for acts or omissions in connection with the access, use, or disclosure of health information obtained through use of the form.**

Charges – Some covered entities may charge a retrieval/processing fee and for copies of medical/psychological records. (Tex. Health & Safety Code § 241.154). See Envision Harmony Counseling Agreement for fees associated with record production.
Right to Receive Copy – The individual and/or the individual's legally authorized representative has a right to receive a copy of this authorization.
Form amended by LaShaun Mwangi, LPC on 01/01/2022