Lourdes M. Valdes, Ph.D.
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Authorization for Disclosure, Use, or Receipt of Protected Health Information

You have the right to refuse to sign this authorization. The provider will not withhold treatment, benefits, or payments processing if you refuse to sign this authorization. You will receive a copy of this signed authorization.

Records and Information Pertaining To: (*please PRINT clearly)*

Client's Name: _____
Last, First Middle

Home Address: _____
Street City State Zip

Client's Date of Birth: _____
Month / day / year

I Authorize: Lourdes Valdes, Ph.D., PLLC
535 E. Fernhurst Dr., Suite #116
Katy, TX 77450
832-437-6260

- ☐ To release and receive records to/from
- ☐ To only release mental health/medical records to
- ☐ To only receive medical/mental health records from
- ☐ To share information verbally

If none of the above is checked, all apply.

_____
Name of Recipient

_____
Address

_____
City State Zip

_____
Phone

_____
FAX

I authorize the source named above to send, as promptly as possible, the records listed below marked by an X or a ✓ in the boxes below. (**The items not to be released have a line drawn through them.**) Page numbers are indicated where appropriate.

- ☐ All mental health records
- ☐ Psychological evaluation(s) and test reports
- ☐ Treatment plan and treatment summary
- ☐ Other health information (please specify below)
- ☐ Clinical/educational impressions and observations
- ☐ Academic or educational records and test reports
- ☐ Admission and discharge summaries

OHI: _____

The requested health information is authorized for ☐ Treatment planning/coordination ☐ Referral/continuity of care
☐ At the request of the individual ☐ Other (please specify):

_____

Note: If you are authorizing disclosure of information, then, except for information related to alcohol or drug abuse treatment, the potential exists for the information described in this authorization to be re-disclosed by the recipient. If the information is re-disclosed, then it is no longer protected by medical privacy laws.

Note: If you are signing as a parent/guardian/managing conservator of a minor or as a guardian of the person of an adult, the information disclosed/used/received may contain references about you and your family.

You have the right to revoke this authorization. To revoke this authorization, you must deliver a written statement, signed by you, to the organization or facility where you gave your authorization (identified above), which provides the date and purpose of this authorization and your intent to revoke it. Your revocation will be effective the date it is received by the organization/facility, except to the extent that the organization/facility has already relied upon your authorization to use or disclose your health information as described in the Notice of Privacy Practices.

Unless this authorization is revoked earlier it will expire on: _____
(date, event, or condition of expiration)

_____ _____
Signature of client 18 and older (or client's representative) Date

_____ _____
Printed name of client (or client's representative) Relationship to client