Adam A. Sauceda, MA, LPC, NCC

12030 Bandera Rd. Ste. 108 - J
Helotes, TX 78023
www.synchronicity-counseling.com
Ph. (210) 853-0503
Fx. 1-888-307-5350

Authorization To Release Healthcare Information

Client's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize **Adam A. Sauceda, MA, LPC, NCC** to release healthcare information of the client named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Adam A. Sauceda, MA, LPC, NCC is permitted to release and/or receive any of the following protected health information via written and/or verbal means, including information regulated by the HIPAA Privacy Rule and its regulations; 42 U.S.C. 290dd-2; Texas Rules of Evidence, and Texas Health and Safety Code §571.015[c].

- ☐ Behavioral Health Evaluation
- ☐ Counseling Progress Notes
- ☐ All Healthcare Information
- ☐ Other: _____

- If you choose not to agree with this request, your benefits or services will not be affected.
- I understand that I may revoke this consent at any time and must do so in writing.
- If you make a request to end this authorization, it will not include information already disclosed.
- You have a right to a copy of this agreement.

☐ **I hereby decline the authorization to release any protected health information.**

_____ _____
Signature (Client, Parent, or Legal Guardian) Relationship of signer (if not client)

_____ _____
Printed Name Date Signed

THIS AUTHORIZATION EXPIRES ONE YEAR AFTER IT IS SIGNED.