

PSYCHOLOGICAL OFFICES - TEXAS

Dr. Susan F. Davenport, Licensed Psychologist
Licenses: (TX # 39542, GA # 1969)
478.922.2365 Office dr.susanfdavenport@outlook.com

Authorization to Release/Obtain Information

This form, when completed and signed by you, authorizes me to release protected health information (PHI) from your clinical record to the person you designate.

I, _____, (Print Patient or Adult Representatives name) authorize my psychotherapist, _____, to release and/or obtain the following information and understand that this information is being released at my request (be specific/detailed of the description of information you want disclosed).

This information should only be released and/or obtained to and/or from (name, address and phone number of the person or persons to whom the information is to be released and/or obtained from):

This authorization shall remain in effect until ONE YEAR FROM DATE BELOW unless otherwise specified by me in the following space: _____.

You have the right to revoke this authorization, in writing, at any time by sending such written notification to this office address. However, your revocation will not be effective to the extent that I have taken action in reliance of the authorization or of this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my psychotherapist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

Signature of Patient or Adult Representative

Patient Name (printed)

Date

Witness Name and Signature (In Office)

If a personal representative of the patient signs the authorization, a description of such representative's authority to act for the patient must be attached.

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Standard Charges for Administrative Services

Release of Records:

Administrative Charge: \$30.00
Copy Charge (per page): \$ 0.30
Copy forms to CD \$30.00
Minimum Fee: \$30.00

Letters:

For any letter requested to Attorneys, Schools, or other entities, the fee will be a minimum of \$30.00. If drafting of the letter exceeds 45 minutes, an additional \$30.00 will be added to the fee, per 30 minute increment.

Disability Forms:

Completion of Forms (per page): \$10.00
Minimum Fee: \$30.00

Minimum Fees for these services will be collected in advance. Remainder of fees will be collected upon completion/delivery of requested services.

**Non-Sufficient Funds (NSF) Fees
(Returned Checks)**

You will be charged a \$50.00 fee per returned/dishonored check from your bank. If a check is submitted for payment to your bank a second or subsequent time and is returned for non-sufficient funds or for any other reason, an additional \$50.00 fee will be assessed per event.

I understand and agree to the fees outlined above.

Name: _____

(Date)

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Policy and Guidelines

Welcome to our practice of mental health services. There are several guidelines and policies that will facilitate our providing you the best possible evaluation and/or treatment. The contents of a counseling, intake, or assessment session are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Texas State Mental Health laws regarding privacy of health records supersede HIPPA rules and regulations. It is the policy of this clinic not to release any information about a client without a signed release of information. Noted exceptions are as follows:

Duty to Warn and Protect

When a client discloses intentions or a plan to harm another person, the health care professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults

If a client states that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the health care professional is required to report this information to the appropriate social service and/or legal authorities.

Professional Misconduct

Professional misconduct by a health care professional must be reported by other health care professionals. In cases in which a professional or legal disciplinary meeting is being held regarding the health care professional's actions, related records may be release in order to substantiate disciplinary concerns.

Court Order

Health care professionals are required to release records of clients when a court order has been placed.

Minor/Guardianship

Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

We will try our best to provide privacy during your visit to our facility. A chance meeting in our lobby with someone who is an acquaintance during an appointment is beyond our control. It is the policy of the clinic to keep the contents of any counseling confidential.

Information about clients may be disclosed in consultations with other professionals in order to provide the best possible treatment. In such cases, the name of the clients, or any identifying information, is not disclosed. Clinical information about the clients is discussed.

I understand all Policies and Procedures presented on this notice:

Patient/Parent/Legal Guardian Signature

Date