

Barbara Jo Stetzelberger, LCSW, BC-DMT  
Licensed Masters In Social Work, Board Certified-Dance Movement Therapist  
11008 Tangleridge Circle  
Austin, TX 78736

## Authorization Mental Health Treatment

I, \_\_\_\_\_ [Insert Name of Patient/Client], whose Date of Birth is \_\_\_\_\_,

authorize Barbara Jo Stetzelberger LCSW, BC-DMT to disclose to and/or obtain from:

\_\_\_\_\_ the following information:

[Insert Name of Person or Title of Person or Organization]

### Description of Information to be Disclosed

(Patient/Client should initial each item to be disclosed)

- |   |   |
|---|---|
| _____ Assessment                          | _____ Educational Information                   |
| _____ Diagnosis                           | _____ Discharge/Transfer Summary                |
| _____ Psychosocial Evaluation             | _____ Continuing Care Plan                      |
| _____ Psychological Evaluation            | _____ Progress in Treatment                     |
| _____ Psychiatric Evaluation              | _____ Demographic Information                   |
| _____ Treatment Plan or Summary           | _____ Psychotherapy Notes*                      |
| _____ Current Treatment Update            | (*Cannot be combined with any other disclosure) |
| _____ Medication Management Information   | _____ Other _____                               |
| _____ Presence/Participation in Treatment | _____ Other _____                               |
| _____ Nursing/Medical Information         |   |

### Purpose

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services.

If the purpose is other than marketing, sale of information, research or as specified above, please specify:

\_\_\_\_\_  
\_\_\_\_\_

### Marketing

- If the purpose of this disclosure is for marketing purposes, please check this box and set forth the financial remuneration amount received by Barbara Jo Stetzelberger LCSW, BC-DMT the in exchange for disclosing the information. \$ \_\_\_\_\_

### Sale of Information

- If the purpose of this disclosure is for the sale, license to use or lease of the information, please check this box.

### Research

- If the purpose of this disclosure is for research purposes, please check this box and identify the current and future research studies as well as whether each research study is conditioned upon execution of this authorization and individual's ability to opt into each study.

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Barbara Jo Stetzelberger LCSW, BC-DMT, 11008 Tangleridge Circle, Austin, TX 78736. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration

Unless sooner revoked, this authorization expires on the following date: \_\_\_\_\_ or as otherwise indicated: \_\_\_\_\_

Conditions

I further understand that Barbara Jo Stetzelberger LCSW, BC-DMT will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences: \_\_\_\_\_

Form of Disclosure

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Redisclosure

I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections.

I will be given a copy of this authorization for my records.

\_\_\_\_\_  
Signature of Patient/Client Date

\_\_\_\_\_  
Signature of Parent, Guardian or Personal Representative Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.).

\_\_\_\_ Check here if patient/client refuses to sign authorization

\_\_\_\_\_  
Signature of Staff Witness Date