Grace Psychological Health Services, PLLC
Dr. LaRonda Starling
1506 W. Pioneer Pkwy, Ste 107
Arlington, Texas, 76013

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

(This form is used to request copies of protected health information. Requests will be subject to a reasonable fee. Please print.)

I, _____, whose date of birth is _____, authorize _____ to disclose to and/or obtain from _____ the following information:

Description of Information to be Requested/Disclosed
(The individual making the request should initial or check each item requested.)

____ Diagnosis

____ Psychological Evaluation Report

____ Information Needed for Evaluation

____ Client History/Diagnostic Information

____ Presence/Participation in Treatment

____ Progress in Treatment

____ Treatment or Discharge Summary

____ Other _____

Person/Entity information is requested to be disclosed to and/or obtained from by Dr. Starling:

Name: _____

Number: _____

Fax: _____

Address: _____

_____

How would you like to receive the information you are requesting?

____ Mail (postage fees paid by client)

____ Office Pick Up

____ Fax (please add a fax number here_____.
The fax will be sent from a HIPAA compliant fax service. If you're not receiving the requested information from a HIPAA compliant fax, but you want it sent there despite this fact, please check here: _____)

Purpose

The purpose of this request/disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services. If other purpose, please specify: _____

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Dr. LaRonda Starling at her office address (1506 W. Pioneer Pkwy, Suite 107 Arlington, Texas, 76013). 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 _____, or as otherwise indicated: _____

Conditions

I further understand that my treatment will not be conditioned 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.

Confidentiality

I will take every reasonable measure to ensure your confidentiality. It is important to note that psychological evaluation reports, if requested to be sent from this office, have limits to confidentiality because information gathered during this time period from clients and/or family/representatives is included in a final report. Furthermore, confidentiality and privileged communication is limited under Texas law and professional codes of ethics. I am required to report any suspicions or evidence of child abuse; abuse of those who are elderly or disabled; a person's intent to take harmful, dangerous, or criminal action against another human being or against himself or herself, and other limitations outlined under the law and professional codes of ethics. Additionally, I disclose confidential information, if required, in the case of lawsuits filed for claims of mental/emotional damages and if you file suit against your Clinician/Therapist for breach of duty.

Redislcosure

Federal law prohibits the person or organization to whom disclosure is made from making any further disclosure of substance abuse treatment information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. Other types of information may be re-disclosed by the recipient of the information in the following circumstances: _____
_____

Consultation/Non-Therapeutic Uses of Information and/or Attendance in Court

The information requested or disclosed should be for the continuation of care to another mental health provider and/or for the client's informational purposes and/or for coordination of care with the client's other health providers. A consultation fee (to be paid by client, or parent if client is a child) of $250/hour is charged in the event that Dr. Starling is needed to consult or communicate with any party that is not the client or parent that is not a counseling session. Payment is due at the time of the communication, and half of the charge will be refunded in the event the communication lasts between 1 to 30 minutes (per communication).

A session fee of $250/hour will be charged in the event that Dr. Starling is requested to obtain or disclose information from or to a third party who is not involved in the client's continuation of therapeutic care (e.g., a licensed professional counselor or other licensed mental health care provider). This includes consultations about the client with said third parties that may not be solely focused on the requested information. Individuals working in the legal profession (i.e., lawyers) are not considered a part of the client's continuation of therapeutic care. I understand that this communication may be in the office or over the telephone, payment is due at the time of the communication, and Dr. Starling does not communicate to or about clients using non-secure methods (i.e., e-mail, text messages).

Additionally, the below schedule of fees may be charged according to the descriptions and are due at time of service:

1.Preparation time (including submission of records): $250/hour
2.Phone calls: $250/hour
3.Depositions: $250/hour
4.Time required in giving testimony: $250/hour
5.Mileage: $0.56/mile
6.Time away from office due to depositions or testimony: $250/hour
7.All attorney fees and costs incurred by the therapist as a result of the legal action.
8.Filing a document with the court: $100
9.The minimum charge for a court appearance: $1500 (due at least 72 business hours before the scheduled court appearance)

Even though you are responsible for the testimony fee and other fees listed above, it does not mean that my testimony and/or professional opinions will be solely in your favor. I can only testify to the facts of the case and to my professional opinion. If a subpoena or notice to meet attorney(s) is received without a minimum of 48-hour notice there will be an additional $250

"express" charge. Also, if the case is reset with less than 72 business hours notice, then the client will be charged $500 (in addition to the retainer of $1500).

I understand that I can request a copy of this authorization for my records.

_____

Signature of 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.

_____

_____

_____ Check here if client refuses to sign authorization.

_____

Signature of Staff Witness Date