



## Authorization and Release of Information

**Client Name:**

**DOB:**

I, (Client/Guardian),  
Authorize, **"Let's Talk" Therapy and Supervision, Inc. and its staff** to disclose to and/or obtain  
from:

**DOB:**

the following information:

Description of Information to be Disclosed Verbally and/or Written

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

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

### 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.

2458 W. Newell St.  
Wichita, KS 67203  
Angela@letstalkwichita.com  
316.804.5135 v 316.847.7082 f



Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to **“Let’s Talk” Therapy and Supervision, Inc.** at [angela@letstalkwichita.com](mailto:angela@letstalkwichita.com). 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 Angela Holoubek, LSCSW, RPT-S, MTS with **“Let’s Talk” Therapy and Supervision, Inc.** 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:

None

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.

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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, if I request a copy.

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Signature of Client Date

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Signature of Parent, Guardian or Personal Representative/Authority 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.).

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Check here if patient/client refuses to sign authorization

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Signature of Staff Witness Date

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