**Family Renewal Therapy**

I am committed to being with you through your entire journey

817-993-9666 || Keller, TX 76248

**AUTHORIZATION FOR**

**THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**

I, , the undersigned client of Family Renewal Therapy of Keller, do hereby authorize Shireen Khan, LMFT-A, my treating mental health provider, to disclose **any and all** protected health information in my file, included but not limited to psychotherapy notes to the following persons and/or agencies:

I also give authorization for Family Renewal Therapy to obtain **any and all** protected health information from the following persons and/or agencies:

This information is to be provided at my request for use by the entity(ies) specified above **only** in connection with: Mental Health Treatment

This authorization shall expire on and/or on the conclusion of any and all appeals.

I acknowledge that I have the right to revoke this authorization in writing at any time to the extent Family Renewal Therapy, has not taken action in reliance on this authorization. I further acknowledge that even if I revoke this authorization, the use and disclosure of my protected health information could possibly still be compelled by Court Order under state law as indicated in the copy of the Privacy Notice of Family Renewal Therapy, that I have received and reviewed.

I acknowledge that I have been advised by Family Renewal Therapy, of the potential of re-disclosure of my protected health information by the authorized recipients and that it will no longer be protected by the federal Privacy Rule.

I further acknowledge that the treatment provided to me by Family Renewal Therapy, was not conditioned on my signing this authorization.

Signed this day of , 20 .

Client DOB

Parent (If client is a minor child) Therapist: Shireen Khan, LMFT-Associate

 (Supervisor Don Zablosky, LMFT-S)