Libby Fischer-Osborne, LPC

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Authorization to Disclose Protected Health Information

This form will allow Libby Fischer-Osborne, LPC to discuss protected health information (PHI) with the person(s) or institution named below. This information will not be released without your signed authorization. This PHI may include assessment reports, diagnosis, treatment plan, progress notes (written or verbal) and any other specified information requested.

Authorization is given for the release of

Yes	No	PLEASE INITIAL	Yes	No	PLEASE INITIAL
___	___	Assessment Reports	___	___	Progress Notes (written)
___	___	Diagnosis	___	___	Progress Notes (verbal)
___	___	Treatment Plan	___	___	Other (Specify) _____

I, _____, authorize Libby Fischer-Osborne, LPC
Client Name
to release protected health information related to my evaluation and treatment to:

Name: _____ Phone: _____

Address: _____
Street City/State Zip

In addition,

I, _____, authorize _____
Client Name Name of person(s) or institution noted above

to release protected information related to my evaluation and treatment to Libby Fischer-Osborne, LPC.

You can end this authorization at any time by contacting Libby Fischer-Osborne, LPC in writing at:
Libby Fischer-Osborne, LPC ◆ 6750 Hillcrest Plaza Drive, Suite 304 ◆ Dallas, TX 75230 ◆ Phone: 214-288-9241

If you make a request to end this authorization it will not include information that has already been used or disclosed based on your previous permission.

You cannot be required to sign this form as a condition of treatment, payment, enrollment, or eligibility for benefits.

- You have a right to a copy of this signed authorization. Please keep a copy for your records.

_____ _____
Client Signature Date

_____ _____
Parent (If Client is a minor) Date