Leslie Ann Shields, M.S., L.P.C.

• 832. 858.1411 • www.lashields.com

AUTHORIZATION TO RELEASE INFORMATION

I, (name of client) _____, (hereinafter "Client") hereby authorize (name of psychotherapist) ***Leslie Ann Shields*** , (hereinafter "Provider") to disclose mental health treatment information and records obtained in the course of psychotherapy treatment of Client, including, but not limited to, psychotherapist's diagnosis of Client, to

NAME of DARS VRC: _____

DARS OFFICE: _____

PH#:_____

I understand that I have a right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing. I understand that I have the right to revoke this authorization at any time unless Provider has taken action in reliance upon it. And, I also understand that such revocation must be in writing and received by Provider at P.O. Box 70494 Houston, TX 77270 to be effective.

This disclosure of information and records authorized by Client is required for the following purpose ***Support of my DARS vocational rehabilitation plan designed and agreed upon between myself and my DARS VRC, which included referral of services to this therapist as part of my rehab plan.*** **(client/guardian initials:_____)**

The specific uses and limitations of the types of medical information to be discussed are as follows: ***Client's progress relating management of disability symptoms via developing & using psychological coping strategies for identifying & processing underlying psychological issues impacting client's vocational rehabilitation success.***

(client/guardian initials:_____)

Such disclosure shall be limited to the following specific types of information:

Client's quantity and quality of participation and pertinent information disclosed within session with Therapist named above including, but not limited to individual, group, family, educational or assessment sessions as they relate to client's vocational rehabilitation. **(client/guardian initials:_____)**

Psychotherapist shall not condition treatment upon Client signing this authorization and Client has the right to refuse to sign this form. Client understands that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by the HIPAA privacy rule, although applicable Texas law may protect such information.

This authorization shall remain valid for one year from the date this authorization was originally signed.

Client's (or authorized guardians's) signature: _____ Date: _____