

Authorization for Use and/or Disclosure of Protected Health Information

I authorize the use and/or disclosure of my protected health information by The Life Empowerment Center, including "Therapist" James Ochoa and all employees as described below:

1. My authorization applies only to the information checked below. Only this information may be used and/or disclosed pursuant to this authorization (check all that apply):
 - a. Confirmation that I have contacted the Office of Therapist.
 - b. Number of times I have contacted the Office of Therapist.
 - c. Information discussed regarding my job performance.
 - d. Recommendations for treatment and whether I followed that treatment.
 - e. Summary of assessment done by the Therapist or Therapist's employees.
 - f. Other _____.

2. I authorize the following persons (or class of persons) to make the authorized use and/or disclosure of my protected health information:
 a. Therapist b. Therapist's Employees

3. I authorize the following persons (or class of persons) to receive my protected health information (i.e. my spouse, employer, doctor, etc.): _____

4. I understand that, if my protected health information is disclosed to someone who is not required to comply with state and federal privacy protection laws and regulations, such information may be re-disclosed and would no longer be protected.

5. I understand that I have a right to revoke this authorization at any time. My revocation must be in writing. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization. Any request to revoke this authorization must be sent in writing to The Life Empowerment Center at 2111 Dickson Drive, Suite 14, Austin, Texas, 78704.

6. This authorization expires one month after the end of my treatment by Therapist.

7. I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from Therapist, nor will it affect my eligibility for benefits.

8. I understand that I have a right to inspect and copy my own protected health information to be used or disclosed, (in accordance with state laws and regulations and the requirements of the federal privacy protection regulations found under 45 C.F.R. § 164.524), except when Therapist has the legal right to refuse such access.

I certify that I have received a copy of the authorization.

Client Signature: _____ Date: _____

Client Name: _____

Parent Signature if Required: _____

**The Life Empowerment Center
James Ochoa, LPC, Inc.**

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