



**Lourdes M. Valdes, Ph.D.**  
Licensed Clinical Psychologist

Office: 832-437-6260  
Fax: 888-972-6230  
lourdes@drvaldes.net  
drvaldes.net

## Authorization for Disclosure, Use, or Receipt of Protected Health Information

You have the right to refuse to sign this authorization. The provider will not withhold treatment, benefits, or payments processing if you refuse to sign this authorization. You will receive a copy of this signed authorization.

**Records and Information Pertaining To:** *(please PRINT clearly)*

Client's Name: \_\_\_\_\_  
Last, First Middle

Home Address: \_\_\_\_\_  
Street City State Zip

Client's Date of Birth: \_\_\_\_\_  
Month / day / year

I Authorize: Lourdes Valdes, Ph.D., PLLC  
633 E. Fernhurst Dr., Suite #501  
Katy, TX 77450  
832-437-6260

To release and receive records to/from  
 To only release mental health/medical records to  
*If none of the above is checked, all apply.*

\_\_\_\_\_  
Name of Recipient

\_\_\_\_\_  
Address

\_\_\_\_\_  
City State Zip

\_\_\_\_\_  
Phone

\_\_\_\_\_  
FAX

I authorize the source named above to send, as promptly as possible, the records listed below marked by an X or a ✓ in the boxes below. **(The items not to be released have a line drawn through them.)** Page numbers are indicated where appropriate.

- |  |  |
|--|--|
| <input type="checkbox"/> All mental health records                       | <input type="checkbox"/> Clinical/educational impressions and observations |
| <input type="checkbox"/> Psychological evaluation(s) and test reports    | <input type="checkbox"/> Academic or educational records and test reports  |
| <input type="checkbox"/> Treatment plan and treatment summary            | <input type="checkbox"/> Admission and discharge summaries                 |
| <input type="checkbox"/> Other health information (please specify below) |  |

OHI: \_\_\_\_\_

The requested health information is authorized for  Treatment planning/coordination  Referral/continuity of care  
 At the request of the individual  Other (please specify):

**Note:** If you are authorizing disclosure of information, then, except for information related to alcohol or drug abuse treatment, the potential exists for the information described in this authorization to be re-disclosed by the recipient. If the information is re-disclosed, then it is no longer protected by medical privacy laws.

**Note:** If you are signing as a parent/guardian/managing conservator of a minor or as a guardian of the person of an adult, the information disclosed/used/received may contain references about you and your family.

You have the right to revoke this authorization. To revoke this authorization, you must deliver a written statement, signed by you, to the organization or facility where you gave your authorization (identified above), which provides the date and purpose of this authorization and your intent to revoke it. Your revocation will be effective the date it is received by the organization/facility, except to the extent that the organization/facility has already relied upon your authorization to use or disclose your health information as described in the Notice of Privacy Practices.

Unless this authorization is revoked earlier it will expire on: \_\_\_\_\_  
(date, event, or condition of expiration)

\_\_\_\_\_  
Signature of client 18 and older (or client's representative)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of client (or client's representative)

\_\_\_\_\_  
Relationship to client