

ADAM D. COFFEY, PH.D.
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Bilateral Authorization to Exchange Professional Information

This form fully protects your civil liberties and abides by standards within the Health Insurance Portability and Accountability Act (HIPAA) when the following conditions are met:

- 1 All blanks have been filled out prior to your signing it;**
- 2 Signing this is not required as a condition of treatment unless Dr. Coffey's professional and/or ethical codes require him to disclose information;**
- 3 That you sign it only after a specific request for information has been made;**
- 4 That you fully understand that the release is limited to include only the agency (or agencies) or individual(s) named below.**

I AUTHORIZE: Adam D. Coffey, Ph.D.

TO EXCHANGE PROFESSIONAL INFORMATION WITH:

IN REGARD TO (WHOM):

FOR THE PURPOSE OF: Treatment collaboration

Any information you authorize other professionals to release to Dr. Coffey will be held strictly confidential and will not be released without your permission, within the legal limits of the state of Texas and the ethical codes of the American Counseling Association (ACA) and the American Association for Marriage and Family Therapy (AAMFT). This authorization expires in 90 days from the date below, and you may revoke it at any time and for any reason by telling Dr. Coffey. Please keep in mind that information disclosed under this authorization may be re-disclosed by the identified person(s) above and may no longer be protected by our therapeutic confidentiality.

Signature _____
(Client)

Date _____

Signature _____
(Parent/Guardian, if client is a minor)

Date _____

Witness _____

Date _____