

Healing Steps Family Therapy, LLC

Group Practice | Stephen M. Stepanovich, MS, LMFT, CEO
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AUTHORIZATION TO RELEASE OR EXCHANGE HEALTH INFORMATION

Form 03-A · General records (does not include psychotherapy notes)

This form lets you give us written permission to share your health information. Please fill in every section. If a required section is left blank, this authorization is not valid. Ask us if anything is unclear.

1. Client

Client name: _____ Date of birth: _____

Client 2 name (couples/family records only): _____ Date of birth: _____

Therapist: _____

2. Who may share the information

I authorize **Healing Steps Family Therapy, LLC**, 3175 E. Warm Springs Rd., Suite 111, Las Vegas, NV 89120, (702) 743-4497, including my therapist named above and the practice's clinical and administrative staff, to:

☐ Release (send) my information to ☐ Obtain (receive) my information from ☐ Exchange information both ways with the person or organization listed in Section 3.

If I checked "Obtain" or "Exchange," I also authorize the person or organization in Section 3 to release the information checked in Section 4 to Healing Steps Family Therapy, LLC.

3. Who may receive the information

Name of person and/or organization: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax/Secure email: _____

4. What information may be shared

Check each item you agree to share. Be as specific as you can.

Dates of service covered: ☐ All dates ☐ From _____ to _____

☐ Confirmation that I am a client, and my attendance dates

☐ Diagnosis

☐ Treatment plan, goals, and progress summary

☐ Assessment or screening results

☐ Medication information reported to my therapist

☐ Discharge or treatment summary

☐ Billing and payment records

☐ Spoken (verbal) discussion between my therapist and the recipient

☐ Other (describe): _____

Psychotherapy notes are NOT included in this authorization. Psychotherapy notes are a therapist's separate private notes about the content of sessions, kept apart from the rest of the record. Sharing them requires a separate authorization (Form 03-B, Part B below). ☐ I understand.

5. Sensitive information (optional — initial only the items you agree to share)

Some types of information have extra legal protections and may need your specific permission. If you do not initial an item, it will not be shared under this form.

_____ Substance use disorder (alcohol or drug) diagnosis or treatment information

_____ HIV/AIDS or other communicable disease test results or status

_____ Genetic testing information

_____ Other sensitive information (describe): _____

6. Why the information is being shared

☐ At my request

☐ Coordination of care with another treating provider

☐ School or educational planning

☐ Legal or court matter that I am involved in

☐ Insurance, disability, or benefits claim

☐ Other (describe): _____

7. When this authorization ends (required — fill in one)

☐ On this date: _____ ☐ When this event happens:

_____ (for example, "when my treatment at Healing Steps ends")

8. Your rights — please read

- **You may cancel (revoke) this authorization at any time, in writing.** Mail or deliver a signed note to Healing Steps Family Therapy, LLC, 3175 E. Warm Springs Rd., Suite 111, Las Vegas, NV 89120, or email stephen@healingvegas.com. Your cancellation takes effect when we receive it. It does not undo anything we already shared, or any action we already took, based on this authorization before we received your cancellation. Our Notice of Privacy Practices also explains how to revoke; it is available at healingvegas.com and in the office.
- **Signing is your choice.** We will not condition your treatment, payment, enrollment in a health plan, or eligibility for benefits on whether you sign this form. You may refuse to sign.
- **Once shared, the information may no longer be protected.** The person or organization that receives your information may share it again (redisclose it), and federal privacy law (HIPAA) may no longer protect it.
- You may look at or get a copy of the information that will be shared.
- **You will receive a copy of this signed form.**

9. Signatures

Couples and family records: when the information to be shared includes more than one adult client, each adult whose information will be shared must sign. A minor's information requires the signature of a parent or legal guardian.

Client 1 (or personal representative) — Name
(please print)

Signature

Date

Client 2 (or personal representative) — Name
(please print)

Signature

Date

If signed by a personal representative, describe your authority to act for the client (for example, parent of a minor, legal guardian, or health care power of attorney) and attach documentation if available:

Office use: ☐ Copy given to client on _____ by _____ ☐ Revoked on _____

AUTHORIZATION TO RELEASE PSYCHOTHERAPY NOTES

Form 03-B · Separate authorization — psychotherapy notes only

Healing Steps Family Therapy, LLC · 3175 E. Warm Springs Rd., Suite 111, Las Vegas, NV 89120 · (702) 743-4497 ·
stephen@healingvegas.com

Client name: _____ Date of birth: _____

Client 2 name (couples/family notes only): _____ Date of birth: _____

Therapist who wrote the notes: _____

Who may share: I authorize Healing Steps Family Therapy, LLC and the therapist named above to release the psychotherapy notes described below.

Who may receive: Name/organization: _____ Address: _____
Phone/Fax: _____

What will be shared: ☐ I authorize release of my psychotherapy notes (the therapist's separate notes about the content of sessions) for these dates: ☐ All dates ☐ From _____ to _____. Other limits (optional): _____

Why: ☐ At my request ☐ Other (describe): _____

This authorization ends (required — fill in one): ☐ On this date: _____ ☐ When this event happens: _____

Your rights

- You may cancel (revoke) this authorization at any time, in writing, by mailing or delivering a signed note to Healing Steps Family Therapy, LLC, 3175 E. Warm Springs Rd., Suite 111, Las Vegas, NV 89120, or emailing stephen@healingvegas.com. Cancelling does not undo anything already shared, or any action already taken, based on this authorization before we received your cancellation.
- Signing is your choice. We will not condition your treatment, payment, enrollment in a health plan, or eligibility for benefits on whether you sign this form.
- The person or organization that receives your psychotherapy notes may share them again, and federal privacy law (HIPAA) may no longer protect them.
- You will receive a copy of this signed form.

Couples and family notes: each adult whose information appears in the notes must sign.

_____	_____	_____
Client 1 (or personal representative) — Name (please print)	Signature	Date

_____	_____	_____
Client 2 (or personal representative) — Name (please print)	Signature	Date

If signed by a personal representative, describe your authority to act for the client:

Office use: ☐ Copy given to client on _____ by _____ ☐ Revoked on _____