Koppa Counseling, PLLC
Rachel W. Koppa, PhD, LPC-S, LMFT
12720 Hillcrest Road Suite 120
Dallas, TX 75230
214-224-0970
www.koppacounseling.com
rachel@koppacounseling.com

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 Rachel W. Koppa, PhD, LPC-S, LMFT professional and/or ethical codes require her 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: **Rachel W. Koppa, PhD, LPC-S, LMFT**

TO EXCHANGE PROFESSIONAL INFORMATION WITH:

IN REGARD TO (WHOM):

FOR THE PURPOSE OF: Treatment collaboration

Any information you authorize other professionals to release to Rachel W. Koppa, PhD, LPC-S, LMFT will be held strictly confidential and will not be released without your permission This authorization expires in 90 days from the date below, and you may revoke it at any time and for any reason by telling, Rachel W. Koppa, PhD, LPC-S, LMFT. 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 _____ Date
(Client)
Signature _____ Date
(Parent/Guardian, if client is a minor)

Witness _____ Date