

Supported Decision-Making Agreement
and
Authorization to Release Confidential Information
under a Supported Decision-Making Agreement

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COLLIN COUNTY BAR ASSOCIATION
ESTATE PLANNING AND PROBATE SECTION
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Supported Decision-Making Agreement

This agreement is governed by the Supported Decision-Making Act, Chapter 1357 of the Texas Estates Code. This supported decision-making agreement is to support and accommodate an individual with a disability to make life decisions, including decisions related to where and with whom the individual wants to live, the services, supports, and medical care the individual wants to receive, and where the individual wants to work, without impeding the self-determination of the individual with a disability. This agreement may be revoked by the individual with a disability or his or her supporter at any time. If either the individual with a disability or his or her supporter has any questions about the agreement, he or she should speak with a lawyer before signing this supported decision-making agreement.

Appointment of Supporter:

I (Name of Adult with Disability), _____ am entering into this agreement voluntarily.

I choose (Name of Supporter) _____ to be my Supporter.

Supporter's Address: _____

Phone Number: _____

E-mail Address: _____

My Supporter may help me with life decisions about:

Yes ___ No ___ obtaining food, clothing and a place to live

Yes ___ No ___ my physical health

Yes ___ No ___ my mental health

Yes ___ No ___ managing my money or property

Yes ___ No ___ getting an education or other training

Yes ___ No ___ choosing and maintaining my services and supports

Yes ___ No ___ finding a job

Yes ___ No ___ Other: _____

My Supporter does not make decisions for me. To help me make decisions, my Supporter may:

1. Help me get the information I need to make medical, psychological, financial, or educational decisions;
2. Help me understand my choices so I can make the best decision for me; or
3. Help me communicate my decision to the right people.

Yes ___ No ___ My Supporter may see my private health information under the Health Insurance Portability and Accountability Act of 1996. I will provide a signed release.

Yes ___ No ___ My Supporter may see my educational records under the Family Educational Rights and Privacy Act of 1974 (20 U.S.C. Section 1232g). I will provide a signed release.

This agreement starts when signed and will continue until _____ (date) or until my Supporter or I end the agreement or the agreement ends by law.

Signed this _____ (day) of _____ (month), _____ (year)

(Signature of Adult with Disability)

(Printed Name of Adult with Disability)

CONSENT OF SUPPORTER

I (Name of Supporter), _____ consent to act as a Supporter under this agreement.

(Signature of Supporter)

(Printed Name of Supporter)

I (Name of Supporter), _____ consent to act as a Supporter under this agreement.

(Signature of Supporter)

(Printed Name of Supporter)

Notary Public

State of Texas

County of Collin

This document was acknowledged before me on _____ (date)

By _____ and By _____ and
(Name of Adult with a Disability) (Name of Supporter)

By _____
(Name of Supporter)

(Signature of Notary)

WARNING: PROTECTION FOR THE ADULT WITH A DISABILITY

If a person who receives a copy of this agreement or is aware of the existence of this agreement has cause to believe that the adult with a disability is being abused, neglected, or exploited by the supporter, the person shall report the alleged abuse, neglect, or exploitation to the Department of Family and Protective Services by calling the Abuse Hotline at **1-800-252-5400** or online at **www.txabusehotline.org**.

DUTY OF CERTAIN PERSONS WITH RESPECT TO AGREEMENT

A person who receives the original or a copy of a supported decision-making agreement shall rely on the agreement. A person is not subject to criminal or civil liability and has not engaged in professional misconduct for an act or omission if the act or omission is done in good faith and in reliance on a supported decision-making agreement

**AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION
UNDER A SUPPORTED DECISION-MAKING AGREEMENT**

NAME OF ADULT WITH A DISABILITY

Last First Middle

DATE OF BIRTH _____

ADDRESS _____

CITY _____ **STATE** _____ **ZIP** _____

PHONE (____) _____ **ALTERNATE PHONE** (____) _____

I ALLOW THE FOLLOWING PERSON, PROVIDER OR ORGANIZATION TO RELEASE MY INFORMATION, WHICH MAY INCLUDE PROTECTED HEALTH INFORMATION:

REASON FOR RELEASE
(Choose only one option below)

Name _____
Address _____
City _____ State _____ Zip _____
Phone (____) _____ Fax (____) _____

- Treatment/Continuing Medical Care
- Personal Use
- Legal Purposes
- School
- Employment
- Other _____

Name of Supporter Who Can Receive the Confidential Information?

Name _____
Address _____
City _____ State _____ Zip _____
Phone (____) _____ Fax (____) _____

WHAT INFORMATION CAN BE RELEASED? Complete the following by choosing those items that you want released. Check one of the following:

1. HEALTH/MENTAL HEALTH INFORMATION

- All health/mental health information:
- Only the following health/mental health information: _____

Your initials are required to release the following information:

____ Psychotherapy Notes _____ Drug, Alcohol, or Substance Abuse Records
____ HIV/AIDS Test Results/Treatment

2. CASE-RELATED INFORMATION

- My entire case file/records
- Only the following case-related information: _____

3. EDUCATION/SPECIAL EDUCATION INFORMATION

- All education/special education records
- Only the following education/special education records: _____

4. EMPLOYMENT INFORMATION

- All employment records
- Only the following employment information: _____

5. FINANCIAL/PROPERTY INFORMATION

- All financial/property records
 - Only the following financial/property information: _____
-
-

6. HOUSING INFORMATION

- All housing records
 - Only the following housing information: _____
-
-

7. SUPPORTS AND SERVICES

- All records related to any supports and services provided to me
 - Only the following supports and services information: _____
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PURPOSE OF AUTHORIZATION: I have entered a supported decision-making agreement with my supporter. I only authorize the release of my confidential information to my supporter so that my supporter can help me obtain a copy of the confidential information, help me understand the information contained in this confidential information and help me communicate my decisions based on this confidential information. My supporter shall ensure that my confidential information is kept privileged and confidential and is not subject to unauthorized access, use or disclosure. My supporter may only release my confidential information to any other person, provider or organization with my permission. I also retain the right to obtain my confidential information on my own without the help of my supporter.

EFFECTIVE TIME PERIOD. This authorization is valid until my death; the end of my supported decision-making agreement; my permission is withdrawn; or until (date): Month ____ Day ____ Year ____.

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to release information to my supporter.

SIGNATURE AUTHORIZATION: I agree to the release of my confidential information to my supporter. I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that I cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits. I have read and agree with how my confidential information may be used and shared with my supporter.

SIGNATURE _____
Signature of Adult with Disability

DATE

IMPORTANT INFORMATION ABOUT THE AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Developed Pursuant Texas Health & Safety Code § 181.154(d)

Effective October 1, 2015

This authorization is based on a standard Authorization to Disclose Protected Health Information adopted by the Attorney General of Texas in accordance with Texas Health & Safety Code § 181.154(d). This form is intended for use in complying with the requirements of the Health Insurance Portability and Accountability Act and Privacy Standards (HIPAA) and the Texas Medical Privacy Act (Texas Health & Safety Code, Chapter 181). **Covered Entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.**

Covered entities must obtain a signed authorization form from the individual or the individual's legally authorized representative to electronically release that individual's protected health information.

The authorization provided by use of this form means that the organization, entity or person authorized can release, communicate, or send the named individual's protected health information to the organization, entity or person identified on this form, including through the use of any electronic means.

Definitions – In the form, the terms “treatment,” “healthcare operations,” “psychotherapy notes,” and “protected health information” are as defined in HIPAA (45 C.F.R. §164.501). “Legally authorized representative” as used in the form includes any person authorized to act on behalf of another individual. (Tex. Occ. Code § 151.002(6); Tex. Health & Safety Code §§ 166.164, 241.151; and Tex. Probate Code § 3(aa)).

Health/Mental Health Information to be Released – If “All Health/Mental Health Information” is selected for release, health/mental health information includes, but is not limited to, all records and other information regarding health/mental health history, treatment, hospitalization, tests, and outpatient care, and also educational records that may contain health/mental health information. As indicated on this form, specific authorization is required for the release of information about certain sensitive conditions, including:

- Psychotherapy notes.
- Drug, alcohol, or substance abuse records.
- Records or tests relating to HIV/AIDS.

Note on Release of Health Records – This form is not required for the permissible disclosure of an individual's protected health information to the individual or the individual's legally authorized representative. (45 C.F.R. §§ 164.502(a)(1)(i), 164.524; Tex. Health & Safety Code § 181.102). If requesting a copy of the individual's health records with this form, state and federal law allows such access, unless such access is determined by the physician or mental health provider to be harmful to the individual's physical, mental or emotional health. (Tex. Health & Safety Code §§ 181.102, 611.0045(b); Tex. Occ. Code § 159.006(a); 45 C.F.R. § 164.502(a)(1)). If a physician or mental health professional makes such a determination, DRTx will advise the individual about how the individual may seek access to these records under state or federal law.

Limitations of this form – This authorization form should only be used for the release of psychotherapy notes when the individual specifically requests the release of psychotherapy notes. **Use of this form does not exempt any entity from compliance with applicable federal or state laws or regulations regarding access, use or disclosure of health information or other sensitive personal information (e.g., 42 C.F.R. Part 2, restricting use of information pertaining to drug/alcohol abuse and treatment), and does not entitle an entity or its employees, agents or assigns to any limitation of liability for acts or omissions in connection with the access, use, or disclosure of health information obtained through use of the form.**

Charges – Some covered entities may charge a retrieval/processing fee and for copies of medical records (Tex. Health & Safety Code § 241.154).

Right to Receive Copy – The individual and/or the individual's legally authorized representative has a right to receive a copy of this authorization.

Tresi Moore Weeks

Tresi Moore Weeks is an attorney and founder of The Weeks Law Firm, PLLC in Plano, Texas, where she assists clients with estate planning, special needs planning, special needs trusts, probate and guardianship. After 11 years as a trial attorney, she opened her own estate planning law firm 17 years ago. As an advocate for her own child's special needs, she is passionate about helping families with loved ones with special needs.

Tresi serves on the Board of Directors of the Collin County Bar Association and is immediate past president of the Estate Planning and Probate Section. She serves on the Board of Directors of several organizations, including Disability Rights Texas (Vice Chair of the Board), the Association for Independent Living ("AFIL") in Dallas, The Coventry Reserve in Wylie, Estate Planning Council of North Texas and the Dallas Society of Financial Service Professionals. She is on the Advisory Council for My Possibilities. She enjoys her volunteer legal work for the Dallas Volunteer Attorney Program and the Collin County office of Legal Aid of North West Texas.

Tresi is a lifelong learner through her memberships in the National Academy of Elder Law Attorneys, Probate Trust and Estates section of the Dallas Bar Association, the Dallas Estate Planning Council, and the State Bar College. She was voted Best Lawyer in Plano in the Plano Star Courier Reader's Choice Awards 2015.

Tresi is a frequent speaker on special needs trust for attorneys, advisors, educators and parents of children with special needs. She is also a frequent speaker for women's and church groups about basic estate planning and godly stewardship. She lives with her husband Kevin, and they are active members of Watermark Community Church in Dallas.

Education

Baylor University School of Law, J.D., 1987
Baylor University, B.A. in Foreign Service, 1984

Licenses

Texas Supreme Court 1987
U.S. District Court, N. Dist. of TX
U.S. Court of Appeals, 5th Circuit
Certified Texas Guardian Ad Litem and Attorney Ad Litem



AWARDS, ACTIVITIES, MEMBERSHIPS

- Best Lawyer in Plano, Plano Star Courier Readers' Choice Award 2015
- Collin County Bar Association: Board Member; Immediate Past President of the Estate Planning and Probate Section
- Disability Rights Texas: Vice Chair of the Board of Directors, Chair of the PAIMI Advisory Council
- Association for Independent Living, Dallas: Board Member
- Dallas Society of Financial Service Professionals: Board Member
- Estate Planning Council of North Texas: Board Member
- Coventry Reserve: Board Member
- My Possibilities: Advisory Council Member
- National Academy of Elder Law Attorneys: member
- Dallas Bar Association: member of the Probate, Trusts and Estates Section
- Dallas Volunteer Attorney Program: volunteer attorney
- Legal Aid of North West Texas: volunteer attorney
- Dallas Estate Planning Council: member
- State Bar College: member
- Legal Services of North Texas: volunteer, Pro Bono Service Award 1989-91
- Dallas Women Lawyers Association: President 1993, Vice President 1992, Board of Directors 1989-94, member 1988-95
- State Bar of Texas: member of the Real Estate, Probate and Trust Section; Mentor Program for Lawyers Committee 1994-98, Local Bar Services Committee 1994-96

