Compatible Counseling Solutions

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

_____ _____
Client Name Date of Birth

_____
Date Authorization Initiated

I (We) freely and voluntarily authorize Compatible Counseling Solutions to:

___ release and disclose my protected health information to:
____obtain my protected health information from:

_____
Facility/Provider Telephone Number

_____
Address

Protected health information to be disclosed or obtained:

____ Assessment
____ Diagnosis
____ Psychosocial Evaluation
____ Psychological Evaluation
____ Psychiatric Evaluation
____ Treatment Plan or Summary
____ Current Treatment Update
____ Medication Management Information
____ Presence/Participation in Treatment
____ Nursing/Medical Information
____ Educational Information
____ Discharge/Transfer Summary
____ Continuing Care Plan
____ Progress in Treatment
____ Demographic Information
____ Psychotherapy Notes*
(*Cannot be combined with any other disclosure)
____ Other_____
____ Other_____

Purpose

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment when appropriate, coordinate treatment services.

I understand that have the right to revoke this authorization, in writing, at any time by sending notice to Compatible Counseling Solutions. I understand that a revocation is not valid to the extent that Compatible Counseling Solutions has acted in reliance on such authorization.

Expiration

Unless sooner revoked, this authorization expires on the following date:_____ or as otherwise indicated:

_____

Conditions

I further understand that Compatible Counseling Solutions will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences:

_____
_____
_____

A copy of this release shall have the same force and effect as the original.

Form of Disclosure

Unelss you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Redisclosure

I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections.

I will be given a copy of this authorization for my records.

_____ _____
(Client Signature 12 yrs. or older) (Date) (Parent/Guardian Signature)
(Date)

_____ _____
(Witness) (Date) (Relationship)

NOTICE TO RECEIVING FACILITY/THERAPIST: You may not re-disclose any of this information unless the person who consented to this disclosure specifically consents to such re-disclosure.