Authorization for Disclosure of Mental Health Treatment Information

I, _____ , whose date of birth is _____ , authorize Holly French, LPC of Mindful Upstate Counseling to disclose to &/or obtain from:
_____ the following information:

Description of information to be disclosed

_____ Assessment

_____ Diagnosis

_____ Treatment plan or summary

_____ Treatment update

_____ Participation record for treatment

_____ Discharge summary

_____ Continuing care plan

_____ Progress in treatment

_____ Demographic information

_____ Psychotherapy notes (*cannot be disclosed with any other disclosure and is at the discretion of Mindful Upstate to deem if appropriate for disclosure)

Purpose

This information may be used or disclosed in connection with mental health treatment, payment, or healthcare operations.

If the purpose is other than as specified above, please specify:

_____
_____

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Holly French, LPC. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration

Unless sooner revoked, this authorization expires on the following date: _____.

Conditions

I further understand that Holly French, LPC of Mindful Upstate Counseling will not condition my treatment on whether or not 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:
_____.

Form of disclosure

Unless 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.

Re-disclosure

I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be re-disclosed 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.

Signature of client/legal guardian: _____

Date: _____

Signature of witness: _____

Date: _____

_____ Check here if client refuses to sign authorization