Authorization for Mental Health Treatment

I, _____(Name of Authorizing Person), for _____

_____(Client Name) with client DOB_____, authorize:

_____(therapist name)
111 Windel Drive, Suite 213
Raleigh, NC 27609

Tel: 919/807-1454
Fax: 714/276-6999
email: CFLcounseling@gmail.com

to disclose to and/or obtain from: _____ (Name of Person or Title of Person or Organization) the following information:

Description of Information to be Disclosed (Client should initial each item to be disclosed)

_____ Assessment
_____ Psychosocial Information/Evaluation
_____ Current Treatment Update
_____ Medication Management Information
_____ Educational Information
_____ Presence/Participation in Treatment
_____Other_____
_____Other_____

_____ Diagnosis
_____ Treatment Plan or Summary
_____ Demographic Information
_____ Progress in Treatment
_____ Continuing Care Plan
_____ Discharge/Transfer Summary

Purpose

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

If other purpose, please specify: _____

_____

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Change for Living Counseling PLLC. 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 consent expires on the following date: _____ or as otherwise indicated:

Conditions

I further understand that Change for Living Counseling PLLC 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:_____

_____

(Insert an explanation of the consequences, if any, of not signing this authorization, which will depend on the services being provided).

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.

Redisclosure

I understand that there is the potential that the protected health information (PHI) that is disclosed pursuant to this authorization may be redisclosed by the recipient and the PHI 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 Patient/Client Date

_____

Signature of Parent, Guardian or Personal Representative Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.).

_____Check here if patient/client refuses to sign authorization.

_____

Printed Name of Staff Person

_____

Signature of Staff Witness Date