**Authorization for Release of Information**

Client/Family Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[Insert Name of Patient/Client], authorize SS Therapy and Consulting, Ltd to disclose to

and/or obtain from: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ the following information: [Insert Name of Person or Title of Person or Organization]

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

\_\_\_\_\_ Assessment \_\_\_\_\_ Diagnosis

\_\_\_\_\_ Psychosocial Evaluation \_\_\_\_\_ Treatment Plan or Summary

\_\_\_\_\_ Current Treatment Update \_\_\_\_\_ Presence/Participation in Treatment

\_\_\_\_\_ Discharge/Transfer Summary \_\_\_\_\_ Continuing Care Plan

\_\_\_\_\_ Progress in Treatment \_\_\_\_\_ Demographic Information

\_\_\_\_\_\_Psychotherapy Notes\* \_\_\_\_\_\_Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(\*Cannot be combined with any other disclosure)

The purpose for this disclosure is to facilitate effective treatment service coordination. A photocopy or exact reproduction of this form for release of information shall have the same effect as the original. This authorization will automatically expire one year from the date of signature unless a shorter time is specified (specific number of days/months or date): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to SS Therapy and Consulting, Ltd. 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.

I understand that I have the right to review the disclosed information by contacting SS Therapy and Consulting, Ltd.

Unless 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.

Once this authorization has expired or has been revoked, it can be renewed only by proper execution of another authorization. I acknowledge that information to be released may include material that is protected by state and/or federal law, including applicable mental health, alcohol/drug abuse, diagnosis information, or all of these.

My signature authorizes release of only the information specified above. I understand that information authorized by this consent cannot be release to anyone other than those listed above unless given written permission. 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.

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Signature of Patient/Client Date

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Signature of Parent, Guardian and Relationship to Client Date