Krupnick Counseling Associates

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AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Client Name: _____ Date of Birth: _____

I authorize the persons, agencies, or institutions listed below to release verbal and/or written information concerning my current and/or prior medical or psychological treatment. The purpose of this release is to insure continuity of care, to aid in effective treatment, and/or to allow for consultation between professionals. I release the persons, agencies, or institutions from any and all liability for providing such information:

I authorize:	To release to:

_____ Initial here if you are authorizing the parties listed above to exchange information for the purposes outlined.

Please check the types of information/records you would like to have disclosed:

- o Mental health treatment records/information
- o Medication records
- o Medical treatment records/information
- o Psychological reports (including testing)
- o Hospital intake/discharge summaries
- o Substance abuse treatment records/information
- o HIV/AIDS treatment records/information

The purpose of this disclosure is:

_____

I wish to restrict my entered above in the following specific ways:

_____

_____

By signing below, I certify that this request has been made voluntarily, and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this Authorization in writing, at any time, except to the extent that action has already been taken to comply with this . A legible copy of this signed Authorization (e.g., transmitted via facsimile) may be used with the same effectiveness as an original. Unless the purpose of this Authorization is to determine payment of a claim or benefits, my treatment or payment for my treatment cannot be conditioned on the signing of this authorization. I understand that the information that is disclosed may be subject to redisclosure by the recipient, and is no longer protected under the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.

This Authorization expires one year from the date of signature below.

_____ _____

Signature of Client Date Signature of parent/guardian (if applicable) Date

_____

Signature of witness Date

Revocation (if applicable): I hereby revoke the above Authorization.

_____

Signature Date