Authorization of Release of Information for
Mental Health Treatment

I, _____[Insert Name of Patient/Client], whose Date of Birth is _____,

authorize Resolute Counseling 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
_____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_____

____ Presence/Participation in Treatment
____ Diagnosis
____ Psychosocial Evaluation
____ Psychological Evaluation
____ Medication Management Information
____ Psychiatric Evaluation
____ Current Treatment Update
____ Treatment Plan or Summary
_____Other_____

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 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 Michael Linn at 38 Black Avenue Chambersburg PA 17201. 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.

Resolute Counseling
38 Black Avenue
Chambersburg, PA 17201
Phone – 717-264-0450 ~ Fax – 717-264-0460
www.resolutecounseling.com

Expiration

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

Conditions

I further understand that Resolute Counseling 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: _____
_____

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 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.

_____
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

_____
Signature of Staff Witness **Date**

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