



Authorization For Disclosure Of Mental Health Treatment Information

I, _____, whose Date of Birth is _____,
authorize New Waters Counseling LLC to disclose to and/or obtain from:

_____ the following
information:

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

- _____ Assessment
- _____ Diagnosis
- _____ Psychosocial Evaluation
- _____ Psychological Evaluation
- _____ Psychiatric Evaluation
- _____ Treatment Plan or Summary
- _____ Current Treatment Update
- _____ Medication Management Information
- _____ Presence/Participation in Treatment
- _____ Nursing/Medical Information

Purpose

- _____ Educational Information
 - _____ Discharge/Transfer Summary
 - _____ Continuing Care Plan
 - _____ Progress in Treatment
 - _____ Demographic Information
 - _____ Psychotherapy Notes*
- (*Cannot be combined with any other disclosure)
- _____ Other _____

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 New Waters Counseling LLC. 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:

_____ or as otherwise indicated: _____

Conditions

I further understand that New Waters Counseling LLC 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 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 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