

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Client Name: _____

DOB: _____

I authorize Kate McNulty LCSW to: (initial all that apply)

Receive a copy of my specific health information from the person(s) named below

Send a copy of my specific health information to the person(s) named below

To/From: _____

(Name, address and phone number of person who will send or receive information)

I authorize this information to be used for: (initial all that apply)

_____ Continuation of mental health care

_____ Coordination with education services

_____ Coordination with medical providers

_____ Completion of evaluation

_____ Legal issues (*specify*) _____

Coordination of care via phone call

I authorize the exchange of the following information: (initial all that apply)

_____ Mental health session notes

_____ Billing records

_____ Mental health treatment summary

_____ School records

_____ Psychological evaluation reports

Coordination of care via phone call

_____ Other medical records (*specify*) _____

I understand that any information that is exchanged with another person will be protected if that person is required to comply with the Federal Privacy rule. If privacy laws do not apply, the information may not be protected and could be re-disclosed without authorization.

I understand that I may refuse to sign this authorization. My refusal to sign will not prevent me from receiving mental health services or reimbursement for services. The only exception is if the services are solely for the purpose of providing information to someone else and this authorization is necessary to make that disclosure.

I understand that I may revoke this authorization at any time. If I revoke this authorization, it is no longer valid. The only exception is when the authorization was obtained as a condition of obtaining insurance coverage. However, any information exchanged before I revoke this authorization cannot be retrieved. To revoke this authorization, please send a written statement revoking the authorization to:

Unless revoked, this authorization will expire in: (initial one)

_____ one year

on termination of mental health treatment

_____ other (*indicate expiration date or event*): _____

I have read this authorization and I understand it. This completed authorization must be signed by the client or a person authorized by law to represent the client. A copy of this authorization is as valid as the original.

Signature of Client or Client's Representative

Date

Description of representative's authority: _____