Standard Authorization for Disclosure of Mental Health Treatment Information

I, Click or tap here to enter text. [Insert Name of Patient/Client], whose Date of Birth is Click or tap to enter a date. authorize HOLISTIC HEALTH LLC to disclose to and/or obtain from:

Click or tap here to enter text. the following information:
[Insert Name of Person or Title of Person or Organization]

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

☐ Assessment
☐ Psychosocial Evaluation
☐ Psychiatric Evaluation
☐ Current Treatment Update
☐ Presence/Participation in Treatment
☐ Educational Information
☐ Continuing Care Plan
☐ Demographic Information
☐ Diagnosis
☐ Psychological Evaluation
☐ Treatment Plan or Summary
☐ Medication Management Information
☐ Nursing/Medical Information
☐ Discharge/Transfer Summary
☐ Progress in Treatment
☐ Psychotherapy Notes*
(*Cannot be combined with any other disclosure)

☐Other Click or tap here to enter text.
☐Other Click or tap here to enter text.

Purpose
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 Click or tap here to enter text. (Insert Name] at Click or tap here to enter text. [Insert Contact Information].
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: Click or tap to enter a date. or as otherwise Indicated: Click or tap here to enter text.

Conditions
I further understand that HOLISTIQ HEALTH 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: Click or tap here to enter text.
[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 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 stricter than HIPAA and provides additional privacy protections.

I will be given a copy of this authorization for my records.

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Signature of Patient/Client **Date:** Click or tap to enter a date.

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Signature of Parent, Guardian or Personal Representative **Date:** Click or tap to enter a 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

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Signature of Staff Witness: **Date:** Click or tap to enter a date.