The Recovery Room Therapy Services
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Licensed Professional Counselor

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AUTHORIZATION FOR THE RELEASE/EXCHANGE OF INFORMATION

I, _____ (Client's Name), whose Date of Birth is ___/____/___ , authorize **THE RECOVERY ROOM THERAPY SERVICES** to disclose to and/or obtain from:
_____ (The Name of Person or Organization) the following information:
(Client should initial each item to be disclosed)

____ Assessment
____ Psychosocial Evaluation
____ Psychiatric Evaluation
____ Current Treatment Update
____Discharge/Transfer Summary
____ Progress in Treatment
_____Psychotherapy Notes
____ Medication Management Information
_____Other_____

____ Diagnosis
____ Psychological Evaluation
____ Treatment Plan or Summary
____ Educational Information
____ Continuing Care Plan
____ Demographic Information
____Nursing/Medical Information
____ Presence/Participation in Treatment
_____Other_____

Would you like medical records released to your primary care physician ___Yes ___No
If yes, please provided:
PCP Name:_____ Office #_____ Fax_____

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 The Recovery Room Therapy Services at 469.608.9667. 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 The Recovery Room Therapy Services 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 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 client refuses to sign authorization

_____ _____
Signature of Staff Witness Date