RESTORATION COUNSELING

of Rochester, pllc

RELEASE/EXCHANGE OF INFORMATION

I [*Name of Client]:* , whose Date of Birth is , authorize Joyce Wagner, Ph.D., LCSW-R/Restoration Counseling of Rochester to disclose to and/or obtain information from *[Name/Title of Person or Person/ Organization and Phone Number]:*

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

- ☐ Assessment
- ☐ Diagnosis
- ☐ Psychosocial/Psychological Evaluation
- ☐ Treatment Plan Update or Summary
- ☐ Presence/Participation/Progress in Treatment
- ☐ Nursing/Medical Information
- ☐ Discharge/Transfer Summary
- ☐ Continuing Care Plan
- ☐ Psychotherapy Notes* (cannot be combined with any other disclosure)
- ☐ Demographic Information
- ☐ 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 other purpose, please specify:

Revocation: I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to [Insert Name] at [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 consent expires in three years unless otherwise indicated:

Conditions: I further understand that Restoration Counseling of Rochester 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].*

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 protections.

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

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 legal authority to act for this individual (power of attorney, healthcare surrogate, etc.)*

☐ Patient/Client Refuses to Acknowledge Receipt:

Signature of Staff Member Date