Authorization for Disclosure, Use, or Receipt of Protected Health Information

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information no longer can be protected by federal privacy regulations.

I, ________________________________, authorize Full Circle Counseling & Consulting/Rob Novick, LCSW to:
(Print Name) (Print Name)

disclose to __________ (initial) and/or receive from ___________ (initial)

____
(name of person, agency, or organization)

____
(address, city, state, zip code)

____
(phone and fax numbers)

the following written or verbal information from the dates of_______ to_______:

- ___ Assessment Results
- ___ Recommendations
- ___ Social History
- ___ Lab Results
- ___ History and Physical
- ___ Psychiatric Evaluation
- ___ Psychological Testing
- ___ List of medications
- ___ Diagnoses
- ___ Entire Record
- ___ Other ________________
  ____
  ____

The purpose for which this information is being released:

- ___ Coordination of services between providers
- ___ Facilitate family involvement with services
- ___ Coordination of services between agencies/facilities
- ___ Assistance in evaluation and treatment
- ___ Other:______________________
  ____
  ____

I understand this release expires one year from the date the release was signed.

I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and except to the extent that they have already used or disclosed the information in reliance on this Authorization, but if I do it will not have any affect on any actions they took before they received the revocation.

I further acknowledge that the information to be released was fully explained to me and this consent was given of my own free will.

I have reviewed and I understand this Authorization. I also understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.

I acknowledge and understand that I am waiving my right to confidentiality with respect to the records and information released and disclosed pursuant to this consent and hereby release the provider from any and all liability arising from release and disclosure of the information and records requested to whom this information is being released.

____ ____________
(Signature of patient or legal representative) (Date)

____
(Relationship to patient)