Little House on Mackinaw Authorization for Release of Mental Health Records

I,_____, authorize_____to disclose to and/or obtain from_____

regarding_____, DOB_____, the following information: (Each item to be disclosed should be initialed):

_____ Assessment	_____ Presence/Participation in Treatment	_____ Demographic Information
_____ Diagnosis	_____ Educational Information	_____ Photographs
_____ Psychosocial Evaluation	_____ Discharge/Transfer Summary	_____ Current Treatment Update
_____ Treatment Plan/ Summary	_____ Progress in Treatment	_____ 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 the purpose is other than marketing, sale of information, research or as specified above, please specify:

_____

Marketing

☐ If the purpose of this disclosure is for marketing purposes, please check this box and set forth the financial remuneration amount received by the [Social Work Organization] in exchange for disclosing the information.$_____

Sale of Information

☐ If the purpose of this disclosure is for the license to use, please check this box. [for educational purposes.]

Research

☐ If the purpose of this disclosure is for research purposes, please check this box and identify the current and future research studies as well as whether each research study is conditioned upon execution of this authorization and individual's ability to opt into each study:

_____

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to the treating clinician and/or staff at Little House on Mackinaw. 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 treating therapist 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, 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 more strict than HIPAA and provides additional privacy protections. I will be given a copy of this authorization for my records.

_____

Signature of Patient/Client Date

_____ ☐

Signature of Parent, Guardian or Personal Representative Date Check here if patient/client refuses to sign authorization

(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.).

_____

Signature of Witness Date

