Osage Valley Counseling LLC
320 Gravois Rd. Suite 210, Fenton, MO 63026
(636) 600-0446
www.osagevalleycounseling.com

Authorization for Release of Protected Medical Information

I, _____ [PATIENT/CLIENT], whose date of birth is _____, authorize Osage Valley Counseling, LLC in Fenton, MO to disclose to or obtain from the following person/organization.

Name and title of person/organization: _____

Address of person/organization: _____

Phone Number: _____

Email Address: _____

Correspondence may include the following information pertaining to my Protected Health Information (PHI) – Please check all that apply:

- ☐ Assessment
- ☐ Diagnosis
- ☐ Psychosocial Evaluation
- ☐ Psychological Evaluation
- ☐ Psychiatric Evaluation
- ☐ Treatment Plan or Summary
- ☐ Current Treatment Update
- ☐ Client Status Reports
- ☐ Medications/Prescriptions
- ☐ Presence/Participation in Treatment
- ☐ Nursing/Medical Information
- ☐ Discharge/Transfer Summary
- ☐ Continuing Care Plan
- ☐ Progress in Treatment
- ☐ Demographic Information
- ☐ Therapy Progress Notes*
- ☐ Financials or Account Balance
- ☐ Emergency Contact Only
- ☐ Other _____
- ☐ Other _____

This information will be used or disclosed in connection with mental health treatment (including for active legal cases pertaining to foster care or custody arrangements), payment of services, or other healthcare operation purposes.

If the purpose is other than specified above, please provide clarification: _____

_____

This authorization will remain effective for 12 months from the date signed.

I wish for this authorization to expire on _____; instead of remaining in effect for the full 12 months.

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I understand that Osage Valley Counseling, 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: _____

_____

I accept these consequences, and do **NOT** give consent for disclosure of this information.

Printed Name: _____ Signature: _____

Unless you have specified 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, paper form, or electronic form.

I understand that there is the potential for 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.

MO 42 CFR Part 2: I acknowledge that if my health record contains substance use information and/or treatment information, it may also be released as part of the disclosure agreement and within accordance of state law and HIPAA privacy policies. Please indicate in writing if you wish to keep this information protected from further disclosure.

A copy of this authorization will be added to the medical record and available to me through the client portal.

Name of Patient/Client: _____ Guardian: _____

Signature of Patient/Guardian: _____ Date Signed: _____

Staff Witness Signature: _____

Revocation:

I understand that I have a right to revoke this authorization anytime by signing and dating here:

Printed Name: _____ Signature: _____

Effective Date of Revocation: _____

I further understand that revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.