Authorization to Use and Disclose Protected Health Information

Michael Perciful Counseling
509 S Otterbein Avenue Suite 3
Westerville, Ohio 43081
Phone #614-776-4043 – Fax #614-776-4059

NOTICE –PLEASE READ:

I understand that each authorization signed below will remain in effect for 180 days after I sign and date this form. Each authorization may be withdrawn at any time in writing except to the extent that action has already been taken. Upon receipt of written revocation, further release of information shall cease immediately, except as allowed by law. Recipients of the information are forbidden to re-disclose this information without my specific authorization. I understand that my treatment and payment for my services may not be conditioned upon my signing this authorization.

I understand that information disclosed by this authorization may be subject to re-disclosure by the recipient and may no longer be protected by Federal or State confidentiality laws. Michael Perciful Counseling will not be responsible for the misuse or re-release of information by another individual, agency or entity.

NOTICE TO RECIPIENT OF ALCOHOL AND DRUG RELATED INFORMATION: This information has been disclosed to you from records protected by Federal Confidentiality Rules. The Federal Confidentiality Rules prohibit the recipient of this information from making further disclosure of this information unless further disclosure is expressly permitted by the written consent of the medical or other information is not sufficient for this purpose. The Federal Confidentiality Rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse client.

Client Name _____ Date of Birth ____/____/_____

I hereby authorize Michael Perciful Counseling to:

____disclose information ____request information ____exchange information

With (Name of Person or Entity) _____

Address _____

Phone Number _____ Fax Number_____

INFORMATION TO BE USED/DISCLOSED:

Initial the following items needed:

__Diagnostic Assessment/Intake __Progress Notes __Laboratory Report
__Treatment Plan/ISP __Employment Records/Reports __Psychological Evaluation Reports
__Other Social History __School Records/Consultation __Physician's Orders
__Court Reports/Records __Medication Records __Psychiatric Evaluation
__Drug and Alcohol Addiction Records __HIV/AIDS Status
__Other (Clarify Specifically) _____

Purpose for Disclosure:

____Assist in Treatment Planning ____Continuity of Care ____Other (Specify):_____

I understand that I may withdraw this consent at any time in the future as explained above and that this consent WILL expire in 180 days from the date signed below unless otherwise specified.

This consent will expire at (event)_____ or when (condition)_____ or on ____/____/_____ whichever occurs first, not to exceed 180 days.

Signature_____ Facilitator_____
Relationship_____ Witness_____
Date Signed____/____/_____ Date Signed____/____/_____

NOTICE OF REVOCATION:

I hereby revoke authorization for further use and disclosure of my protected healthcare information effective immediately.

Signature_____ Date Signed____/____/_____