Paris Counseling Center, PA

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Standard Authorization for Mental Health Treatment

I, ______________________________*[Insert Name of Client],* whose Date of Birth is ___________, authorize ***Paris Counseling Center, PA*** to disclose to and/or obtain from: ____ the following information:
[Insert Name of Person or Title of Person or Organization]

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

_____ Assessment
_____ Diagnosis
_____ Psychosocial Evaluation
_____ Psychological Evaluation
_____ Psychiatric Evaluation
_____ Treatment Plan or Summary
_____ Current Treatment Update

______Medication Management Information
______Presence/Participation in Treatment
______Nursing/Medical Information
_____ Educational Information
_____ Discharge/Transfer Summary
_____ Continuing Care Plan
_____ Progress in Treatment

_____ Demographic Information
______Psychotherapy Notes*
*(*Cannot be combined with any other disclosure)*
______Other____________________
______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.

Revocation: I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to ***Paris Counseling Center*** at ***3435 Pine Mill Road, Paris, TX 75460***. 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 understand that *Paris Counseling Center* 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 Client   Date

____Check here if client refuses to sign authorization

____
Signature of Parent, Guardian or Personal Representative   Date

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 Staff Witness   Date

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