Serenity Helping Hands Therapy Center, LLC

Authorization to Disclose Protected Health Information

This document is a two-way reciprocal process

Client's Name:	SSN:
Parent/Guardian:	DOB:

I hereby authorize Serenity Helping Hands Therapy Center ("Provider Agency") to disclose to or obtain from (name and/or function of the person or entity to whom disclosure is to be made to or obtained from) the following protected health information:

Agency name to receive and release information:		
Address:		
City:	State	Zip Code
Telephone number:	Fax number:	

__ Entire File ___Psychotherapy Notes ___ Session Start/Stop Times ___ Diagnosis ___ Treatment Plan

____ Symptoms _____ Prognosis ____ Progress to Date ___ Clinical Test Results __ Dates of Treatment

___Intake Assessment ____ Admission Status __Discharge Summary ___Psychosocial/Psychiatric/Psychological Report

____ Modalities & Frequencies of Treatment Furnished ___School Records ___After Care Plan

____ Other ____

I understand that I have a right to receive a copy of this authorization, and that any cancellation or modification of it must be in writing. I understand that I have the right to revoke this authorization at any time unless Provider has taken action in reliance upon it. I also understand that such revocation must be in writing and received by Provider to be effective.

I authorize the disclosure of the health information described above for the following purpose of continuity of care.

The specific uses and limitations on the uses of my health information by Recipient are as follows: ____
____

I understand that Provider cannot condition treatment upon me signing this authorization.

308 Gatehouse Lane ♦ Odenton, Maryland, 21113 ♦ Phone 443-214-8221 ♦ Email: aboone@serenityhhtc.com

I understand that the health information disclosed pursuant to this authorization may be subject to re-disclosure by Recipient and that the Federal Privacy Rule may no longer protect such information, although the re-disclosure of such information may be protected by applicable Maryland law.

Provider is authorized to disclose the protected health information specifically listed above 6 months from the signing and date of this form.

By: ___________________________________ Date: ___________________
Signature of Client or Client's Representative

*If signed by other than Client, please indicate the relationship between Client and his/her Representative: ____