For Disclosure of Mental Health Treatment Information

I,____________________________[Name of Patient/Client], whose Date of Birth is_______,

authorize Holistic Care for Women & Family (HCFW) to disclose to and/or obtain from:

____the following
information: Name of Person or Title of Person or Organization

Description of Information to be Disclosed

(Patient/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

_____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

This information may be used or disclosed in connection with mental health treatment, payment, or healthcare operations.

If the purpose is other than as specified above, please specify:

____

____

Expiration

Unless sooner revoked, this authorization expires on the following date:______________or as otherwise indicated:____

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.

____
Signature of Patient/Client Date

____
Signature of Parent, Guardian or Personal Representative Date