Katie M. Heiden-Rootes, PhD, LMFT
AUTHORIZATION FOR EXCHANGE OF INFORMATION

I understand that:

- I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment
- I may cancel this authorization at any time by submitting a ***written*** request to Katie Heiden-Rootes, PhD, LMFT except where a disclosure has already been made in reliance on my prior authorization, so if I revoke this authorization after a disclosure is made, it will not have any effect on actions taken by Katie Heiden-Rootes in reliance on it before I revoked it.
- The information released may be subject to release by the person(s)/agency receiving it and no longer protected by the federal privacy regulations. If the person of facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.
- Release of HIV-related information requires additional information.
- If the medical record information is not sent to another care provider, there may be a charge of the requested records.
- A photocopy (or fax) of this authorization will be treated in the same manner as the original.
- This release expires in one year unless otherwise noted below.

Client Name: _____ DOB:_____

Address: _____

I authorize Katie Heiden-Rootes, PhD, LMFT to receive information from ☐ and release information to ☐:

Agency: _____AND Individual Contact: _____

Address: _____

Phone: _____ Fax: _____ Email: _____

The following information will be released ☐ verbally and/or in ☐ writing (Check boxes that apply):

☐ All Records and Ongoing Communication OR

☐ Diagnostic Report
☐ Treatment Plan
☐ Progress Report
☐ School Records
☐ Testing Results
☐ Medical History
☐ Case Records
☐ Family History
☐ Referral
☐ Reproductive Records
☐ Psychological/ Psychiatric Evaluation
☐ Ongoing consultation
☐ Discharge Summary
☐ Other: _____

This release is required for the purpose of (Check boxes that apply):

☐ Coordination of services
☐ Planning appropriate treatment
☐ Social service involvement
☐ Continue/ follow-up care
☐ Case review
☐ Reunification Services
☐ Legal/Court involvement
☐ Other: _____

One-time Use/Disclosure: I authorize the one-time use or disclosure of the information described above to the person/provider/organization/facility/program(s) identified.

My authorization will expire:

☐ When the requested information has been sent/received.
☐ 90 days from this date.
☐ Other: _____

Periodic Use/Disclosure: I authorize the periodic/ongoing use/disclosure of the information described above to the person/provider/organization/facility/program(s) identified as often as necessary to fulfill the purpose identified in this document.

My authorization will expire:

☐ 60 days after I am no longer receiving services from Katie Heiden-Rootes, PhD, LMFT to allow for discharge documents to be generated and released.
☐ One year from this date.
☐ Other: _____

Client Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

Provider Signature: _____ Date: _____