LIZ ANDERSON, LICSW

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RELEASE OF INFORMATION

Client Name: _____ DOB: _____

Address: _____ Phone: _____

I authorize Liz Anderson, LICSW to release and/or obtain my protected health information (PHI). I agree that I have signed this release voluntarily and have had any and all questions about releasing information answered and have sufficient understanding of how my information will be used and shared. I release Liz Anderson, LICSW and business associates (e.g., provider of electronic health record) information to the extent indicated and authorized heron. I understand that information used or disclosed pursuant to this authorization could be subject to disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality. Except to the extent allowed by relevant law, Liz Anderson, LICSW, will not refuse to provide treatment based on my refusal to sign this document. I understand that I have the right to revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on it. To revoke this authorization, please do so in writing; such documentation can be sent to Liz Anderson, LICSW 116 Pleasant Street Ste 331 Easthampton, MA 01027.

Please initial where applicable:

____ I authorize Liz Anderson, LICSW to OBTAIN protected health information from the party below

____ I authorize Liz Anderson, LICSW to RELEASE protected health information to the party below.

Party to release information to and/or obtain information from:

Name/Organization: _____

Address: _____

Phone: _____ Fax: _____

For the following dates of treatment:

____ Entire course of treatment ____ Other: _____

Reason for release:

☐ Medical Records ☐ Care coordination ☐ Emergency contact ☐ Other: _____

Information to be released:

☐ Diagnosis ☐ Assessments ☐ Treatment plans ☐ Attendance and scheduling

☐ Risk/safety concerns ☐ Other: _____

Authorization to release specific protected health information (please initial):

____ HIV/AIDS ____ Substance Use Disorder diagnoses/treatment records*

**I understand that my substance use disorder treatment records are protected under federal regulations governing Confidentiality of Substance Use Disorder Patient Records, 42 CFR Part 2. Such records disclosed pursuant to this authorization cannot be redisclosed by the receiving party listed above without my written authorization unless otherwise permitted or required in the regulations.*

Signature: _____ Date: _____

Printed Name: _____

If not signed by client, relationship to client: _____