Brittanie Spraker, LMFT, RPT
Licensed Marriage and Family Therapist
Registered Play Therapist
IN # 35001931A
P.O. Box 173
Flora, IN 46929
P: 765.253.5221
F: 765.807.3156
bspraker@weeplayfamilytherapy.com
info@weeplay.sprucecare.com

Authorization to Disclose Protected Health Information

I, _____, whose Date of Birth is _____, authorize Brittanie Spraker, LMFT, RPT to disclose to and/or obtain from:

_____ the following information:

[Insert Name of Person or Title of Person or Organization]

Phone: _____ Fax: _____Email: _____

Mailing Address: _____

Regarding myself or the following minor: _____DOB: _____ of whom I am the legal guardian or parent.

Description of Information to be Disclosed

____ **Assessment**
____ **Diagnosis**
____ **Results of Psychological and Neuropsychological Testing** *(raw and scaled scores, patient responses to test questions or stimuli, and clinicians' notes and recordings concerning patient statements and behavior during examination; clinician's findings, interpretations and summaries)*
____ **Treatment Plan**
____ **Progress Updates**
____ **Discharge Summary**

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 the right to revoke this authorization in writing at any time by sending written notification to Wee Play Family Therapy, LLC, P.O. Box 173, Flora, IN 46929. 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 exactly one year from the date this release was signed.

Conditions

I further understand that Brittanie Spraker, LMFT, RPT will not condition my treatment on whether I give authorization for the requested disclosure.

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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 Patient Date

_____

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.).

_____**Check here if patient/client/guardian refuses to sign authorization**

_____

Signature of Clinician Date