AUTHORIZATION TO RELEASE/EXCHANGE INFORMATION

I, (name of patient) _____, with a date of birth of _____ (hereinafter "Patient") hereby authorize Sedona Psychotherapy Service, Leslie Filsinger, LPC (hereinafter "Provider") to disclose/exchange mental health treatment information and records obtained in the course of psychotherapy treatment of Patient including, but not limited to HIPAA Protected Health Information (PHI), with/to:

_____

_____

_____

_____

I understand that the information to be released includes records in any form, and oral conversations with the Provider. I understand that I have a right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing. I understand that I have the right to refuse to sign this authorization. I understand that I have the right to revoke this authorization at any time unless Provider has taken action in reliance upon it. And, I also understand that such revocation must be in writing and received by Provider at 16515 S 40th St # 103Phoenix Az 85048 to be effective.

This disclosure of information and records authorized by Patient is required for the following purpose:

Coordination of treatment with another mental health professional involved in your care

Coordination of treatment with another type of health professional involved in your care.

To obtain insurance or other third party benefits under a managed care agreement.

Coordination with another type of professional (e.g., attorney).

To obtain benefits of programs that are not health insurance related (e.g., SSI, SSD, private disability, etc.).

Other

_____

Such disclosure of written or oral conversations shall be limited to the following specific types of information:

Assessment, diagnosis, treatment plan, compliance, functionality, test results, and response to treatment.

Information pertaining to substance abuse or substance dependency.

Sensitive relationship issues, family dynamics, sexual issues, and other highly personal information. This information is contained in Psychotherapy Notes as defined by HIPAA. Authorization to release Psychotherapy Notes can not be combined with a release for other PHI on the same form.

Other

_____

The specific uses of Protected Health Information (PHI) to be discussed or released are as follows

Coordination of response to psychotropic medications prescribed by a psychiatrist or other physician.

Coordination of other medical treatment with mental health, marital, or family treatment

Coordination of marital or family treatment with individual treatment.

Case management and/or utilization review under a managed care agreement.

Review of treatment and/or functionality to obtain benefits of non-health-insurance related programs.

Other

_____

Patient understands that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule, although applicable Arizona law may protect such information. This authorization shall remain valid until:

Patient's signature: _____

Date: _____

Witness (if necessary): _____

Date: _____