I hereby authorize Main Street Counseling and Play Therapy, LLC. and _____to mutually disclose my protected health information as described below: for the following purposes: **(describe each purpose of use/disclosure - If disclosing different types of information below for different purposes, the authorization must specify the purpose for which each type of information is being disclosed.)**

Child and family Treatment and/or _____

I understand that:

1) **THIS AUTHORIZATION IS VOLUNTARY AND I MAY REFUSE TO SIGN THIS AUTHORIZATION WITHOUT AFFECTING MY HEALTH CARE OR THE PAYMENT FOR MY HEALTH CARE**
2) I have the right to request a copy of this form after I sign it as well as inspect or copy any information to be used and/or disclosed under this authorization (if allowed by state and federal law. See 45 CFR § 164.524).
3) I may revoke this authorization at any time by notifying Main Street Counseling and Play Therapy, LLC, in writing as set forth in the Notice of Privacy Practices. However, it will not affect any actions taken before the revocation was received or actions taken in reliance thereon, or if the authorization was obtained as a condition of obtaining insurance coverage and other applicable law provides the insurer with the right to contest a claim under the policy.
4) if the person or organization authorized to receive the information is not a health plan, health care clearinghouse or health care provider, the released information may no longer be protected by federal privacy regulations.

Type of Information to Be Disclosed

☐ Psychological Reports
☐ Psychiatric records progress notes, consultations, assessments, Mental Status Exams, Medication history/reviews
☐ Psycho-educational testing-Speech & lang. eval. – Occupational therapy Evals., academic testing
☐ Most Recent 5 Year History
☐ Placement Reports
☐ Social/Family Home Study reports
☐ DCYF Case plan
☐ Court Orders, court records, police reports
☐ Therapy records, Diagnosis and progress reports
☐ Discharge Summaries
☐ Consultation summaries
☐ I.E.P.
☐ School records
☐ DCYF investigative reports
☐ Psychosocial Evals.
☐ Progress notes
☐ Fire investigations
☐ All current treatment issues
☐ Other _____

_____

_____

In addition, I authorize that this will include health information relating to (check if applicable):

☐ Drug/Alcohol abuse

Expiration: This authorization will expire 180 days from the date of signing or _____.

Client Name: _____ **DOB:** _____

_____ _____
Signature of Client or Legal Representative **Date**

_____
Printed Name of Clients Representative (*if applicable*)

Relationship to Client (*if applicable*)
☐ Parent or guardian of unemancipated minor
☐ Court appointed guardian
☐ Executor or administrator of decedent's estate
☐ Power of Attorney

_____ _____
Signature of Witness **Date**