Restoring Balance Counseling, LLC

Authorization to Release, Obtain, and/or Exchange Information

CLIENT:

_____
(Name of client) (D.O.B.)

_____
(Street Address)

_____
(City, State, Zip Code)

I HEREBY AUTHORIZE:

_____
(Name of Agency/Program/Person)

_____
(Street Address)

_____
(City, State, Zip Code)

To: ☐ **obtain from** ☐ **release to** ☐ **exchange PHI (personal health information) with:**

Restoring Balance Counseling, LLC, 110 W. Linden Dr., Jefferson, WI 53549

Requested dates of release: from _____ to _____

Information to be Disclosed: (Patient/Client/Representative should ***initial*** each item to be disclosed)

_____ ***ALL/ANY INFO APPROPRIATE/NECESSARY FOR OUTPATIENT MENTAL HEALTH TREATMENT (NOTE: initialing this line is consent for all other specific areas listed below)***

_____ Assessment	_____ Diagnosis	_____ Psychotherapy Notes
_____ Discharge/Transfer Summary	_____ Continuing Care Plan	_____ Educational Information
_____ Progress in Tx	_____ Nursing/Medical Info	_____ Psychiatric Evaluation
_____ Treatment Plan(s) or Summary	_____ Demographic Info	_____ Psychosocial Evaluation
_____ Presence/Participation in Tx	_____ Med Management Info	_____ Psychological Evaluation

_____ Other_____

Purpose of Release: 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.

Notices:

Revocation: I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Restoring Balance Counseling, LLC at 110 W. Linden Dr., Jefferson, WI 53549. 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 **12 months** from date signed or as otherwise indicated below: _____.

Conditions: I further understand that Restoring Balance Counseling, LLC will not condition my treatment on whether I give authorization for the requested disclosure.

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. * A copy is as valid as the original. * Upon request, I will be given a copy of this disclosure for my records.

Re-disclosure: I understand that there is the potential that the PHI that is disclosed pursuant to this authorization may be redisclosed by the recipient and the PHI 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.

(X) _____

Client Signature or Person Authorized to Consent (14+ years old) Date

(X) _____

Signers Name (if signed by representative rather than client) Signer's Authority Date

(If you are signing as a personal representative of an individual, please describe your authority to act for this individual (ex. parent, guardian, power of attorney)

_____ Check here if patient/client refuses to sign authorization

_____

Signature of staff Date

110 W. Linden Dr., Suite B, Jefferson, WI 53549
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www.restoringbalancecounseling.com