Elements of Motivation
HIPAA RELEASE OF INFORMATION

I, _____, whose date of birth is _____, authorize

_____ to disclose to and/or obtain from

_____ the following information:

Description of Information to be disclosed
(Client should initial each item to be disclosed.)

_____ Assessment

_____ Diagnosis

_____ Psychosocial Evaluation

_____ Psychological Evaluation

_____ Treatment Plan or Summary

_____ Current Treatment Update

_____ Testing Information

_____ Educational Information

_____ Presence/Participation in Treatment

_____ Continuing Care Plan

_____ Progress in Treatment

_____ Other _____

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. If other purpose, please specify: _____.

Revocation
I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Elements of Motivation. 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 from one year of the date signed or as otherwise indicated: _____.

Conditions

I further understand that Elements of Motivation will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences: lack of coordination of care or failure for progress/engagement to be measured by the entity requesting information.

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 (PHI) that is disclosed pursuant to this authorization may be re-disclosed 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. Other types of information may be re-disclosed by the recipient of the information in the following circumstances, for example, in the case of a DFS court proceeding, treatment information may be presented in court as evidence of progress or regression.

I will be given a copy of this authorization for my records.

Client* Signature _____ Date _____

*Or Parent of Minor, Guardian or Personal Representative- If you are signing as a personal representative of an individual, please describe your authority to act for this individual. Attach appropriate documentation (power of attorney, temporary orders, healthcare surrogate, etc.)

_____

____ Check here if the client refuses to sign authorization.

Signature of Staff Witness _____ Date _____