TRUE NORTH

Psychological Services

Release of Information

I, _______________________________[Insert Name of Patient/Client], whose Date of Birth is ________, authorize [Insert Name of Mental Health Counseling Organization] ______________________to disclose to and/or obtain from:

____ the following information: [Insert Name of Person or Title of Person or Organization]

Description of Information to be Disclosed (Patient/Client should initial each item to be disclosed)

_____ Assessment
_____ Diagnosis
_____ Psychosocial Evaluation
_____ Psychological Evaluation
_____ Psychiatric Evaluation
_____ Treatment Plan or Summary
_____ Current Treatment Update
_____ Medication Management Information

_____ Presence/Participation in Treatment

For Purpose of

_____ Educational Information
_____ Discharge/Transfer Summary
_____ Continuing Care Plan
_____ Progress in Treatment
_____ Demographic Information

______Psychotherapy Notes*
(*Cannot be combined with any other disclosure)
______Other_______________________ ______Other_______________________

This information may be used or disclosed in connection with mental health treatment, payment, or healthcare operations.

If the purpose is other than as specified above, please specify:

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to [Insert Name] at [Insert Contact Information]. 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 on the following date: ________________ or as otherwise indicated: ____

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 stricter than HIPAA and provides additional privacy protections.

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

____Signature of Patient/Client & 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.).

____

Signature of Staff Witness & Date