AUTHORIZATION FOR USE OR DISCLOSURE OF ALCOHOL/DRUG TREATMENT PROTECTED HEALTH INFORMATION

I, _____[Insert Name of Patient/Client], whose Date of Birth is _____,
authorize LifeSolutions Counseling Associates, P.C. to disclose to and/or obtain from:

_____
[Insert Name of Person or Title of Person or Organization and address]

the following Information to be Disclosed: **(Patient/Client needs to 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
_____Nursing/Medical Information

_____ Educational Information
_____ Discharge/Transfer Summary
_____ Continuing Care Plan
_____ Progress in Treatment (Notes)
_____ Demographic Information
_____Psychotherapy Notes*
(*Cannot be combined with any other disclosure like #6)
_____Other_____
_____Other_____

Alcohol or Drug Treatment Records: I do_____/I do not_____ authorize the use of disclosure of drug or alcohol abuse treatment records. I understand that these records are protected under federal regulations (42 CFR Part 2). I understand that I have the right to refuse to release this information. [Send 42 CFR Part 2 advisory with record.]
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 the purpose is other than marketing, sale of information, research or as specified above, please specify: _____

- □ If the purpose of this disclosure is for marketing purposes, please check this box and set forth the financial remuneration amount received by the [Social Work Organization] in exchange for disclosing the information.$_____
- □ If the purpose of this disclosure is for the sale, license to use or lease of the information, please check this box.
- □ If the purpose of this disclosure is for research purposes, please check this box and identify the current and future research studies as well as whether each research study is conditioned upon execution of this authorization and individual's ability to opt into each study. _____.

Revocation: I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to LifeSolutions Counseling at 1185 W. Carmel Dr., STE D4, Carmel, IN 46032. 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:_____

Conditions: I further understand that LifeSolutions Counseling Associates, P.C. 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:

_____
[Insert an explanation of the consequences, if any, of not signing this authorization, which will depend on the services being provided].

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 more strict than HIPAA and provides additional privacy protections.

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

_____ _____
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.).

_____Check here if patient/client refuses to sign authorization

_____ _____
Signature of Staff Witness Date