LIFE CONNECTION COUNSELING

Client Name _____ Date of Birth _____ Date _____

I authorize Life Connection Counseling to ☐ disclose and/or ☐ obtain protected health information that identifies me and to share my protected health information with the person/agencies below:

Name of Persons or Title of Person or Organization _____

_____

_____

Street Address City State Zip Code

Description of Information to be Disclosed or Share (Check one or more boxes below):

- ☐ Assessment
- ☐ Attendance/Participation in Treatment
- ☐ Client Video, Audio, or Photographs
- ☐ Consultation Reports
- ☐ Current Treatment Update
- ☐ Demographic Information
- ☐ Diagnosis
- ☐ Discharge/Transfer Summary
- ☐ Educational Information
- ☐ Progress in Treatment
- ☐ Psychological Evaluation
- ☐ Psychotherapy Notes (if checking this box, no other boxes can be checked)
- ☐ Treatment Plan
- ☐ Other _____
- ☐ Other _____

Description of the Purpose for Disclosure (Check one or more boxes below):

- ☐ Advocacy
- ☐ Share Information Relevant to Treatment
- ☐ Coordination of Treatment Services
- ☐ Court Proceedings and/or Testimony
- ☐ Personal Use
- ☐ Educational Activities
- ☐ Marketing & Promotion of LCC
- ☐ Licensure Supervision
- ☐ Participation in Research Project
- ☐ Other

If other purpose, please specify _____

Expiration
Unless sooner revoked, this authorization expires on the following date _____ (Not longer than one (1) year).

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 matter that we deem appropriate and consistent with acceptable law, including, but not limited to, verbally, in paper format or electronically. If you are requesting access to your own information, we will produce it in an electronic format that you request if it is readily producible in that format, or if not, in a different electronic format on which we can agree.

I understand not all email is secured and individuals not authorized by me may be able to access my protected health information if this information is not sent by mail.

Acknowledgement
I understand that this authorization is voluntary and I may refuse to sign this authorization to release or obtain my records. The refusal will have no effect on receiving services from Life Connection Counseling. I understand that I have the right to inspect the health information to be released and that I may refuse to sign this information.

I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released protected health information may no longer be protected by federal privacy regulations (HIPPA) and may be subject to redisclosure.

Revocation
I understand that I have the right to revoke this authorization, in writing, at any time by sending written notification to Life Connection Counseling. I understand I cannot restrict information that may be already have been shared based on this authorization.

Signature
If the client is a minor, and the treatment provided is related to evaluation related to substance abuse, diagnosis or treatment of a communicable disease, pregnancy, this form must be signed by that minor rather than the parent or legal guardian. If the minor is married, has a court order of emancipation, or lives apart from or is not supported by his or her parents or guardian, this form may be signed by the minor alone.

_____ _____
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 proxy, or guardian etc.).

_____
Capacity of Legal Representative (if applicable)

☐ Staff check here if client refuses to sign authorization

Notice of Redisclosure
Federal law prohibits the person or organization to whom the disclosure is made from making further disclosure of substance abuse treatment information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. I will be given a copy of this authorization for my records.