MW Counseling

hope . wellness . authenticity .

MW COUNSELING

AUTHORIZATION TO RELEASE/EXCHANGE INFORMATION

_____

Client Name Date of Birth:

I, _____, hereby authorize MW Counseling to:

☐ disclose information to
☐ receive information from
☐ exchange information with

_____

Name or Agency Name

_____

Email Address Phone Number

_____

Mailing Address City State Zip

Relationship to client:

☐ Self
☐ Parent/Legal guardian
☐ Other (specify): _____

The specific types of health information to be released are: (Check all that apply)

☐ Assessment
☐ Psychosocial Evaluation
☐ Current Treatment Update
☐ Presence/Participation in Treatment
☐ Mental Health Evaluations
☐ Educational Records/Information
☐ Treatment Plan or Summary
☐ Discharge/Transfer Summary
☐ Psychotherapy Notes
☐ Diagnosis
☐ Psychological Evaluation
☐ Medication Management Information
☐ Medical History and Evaluation(s)
☐ Developmental and/or Social History
☐ Treatment Coordination
☐ Continuing Care Plan
☐ Fees and Services
☐ Other (specify): _____

☐ Progress Notes and Treatment or Closing Summary

Such disclosures shall be limited to the following specific types of information:

☐ Psychiatric diagnosis(es)
☐ Treatment Summary
☐ Full Treatment Record
☐ Dates of Treatment
☐ Initial Treatment Plan
☐ Other (specify): _____

The above information will be used for the following purposes:

☐ Diagnosis/evaluation
☐ Treatment planning/ ongoing treatment
☐ Coordination of services
☐ Determining eligibility for benefits or program
☐ Case review
☐ Case review
☐ Fee payment
☐ Other (specify): _____

This authorization shall remain valid until: _____ (not to exceed one year).

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand that the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules.

I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after one (1) year this consent automatically expires. I understand that any cancellation or modification of this authorization must be in writing. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule, although applicable Arizona law may protect such information.

If you are the legal guardian or representative appointed by the court for the Client, please attach a copy of that documentation to receive this protected health information.

_____

Client Signature Date

_____

Client Name

_____

Parent/Guardian Signature Date

_____

Parent/Guardian Name

_____

Parent/Guardian Signature Date

_____

Parent/Guardian Name