

Debbie Schwartz, LICSW
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Authorization for Release of Information

I, _____ [Insert Name of Patient/Client], whose Date of Birth is _____,
authorize Debbie Schwartz, LICSW, 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)

<input type="checkbox"/> Assessment	<input type="checkbox"/> Educational Information
<input type="checkbox"/> Diagnosis	<input type="checkbox"/> Discharge/Transfer Summary
<input type="checkbox"/> Psychosocial Evaluation	<input type="checkbox"/> Continuing Care Plan
<input type="checkbox"/> Psychological Evaluation	<input type="checkbox"/> Progress in Treatment
<input type="checkbox"/> Psychiatric Evaluation	<input type="checkbox"/> Demographic Information
<input type="checkbox"/> Treatment Plan or Summary	<input type="checkbox"/> Psychotherapy Notes*
<input type="checkbox"/> Current Treatment Update	(*Cannot be combined with any other disclosure)
<input type="checkbox"/> Medication Management Information	<input type="checkbox"/> Other _____
<input type="checkbox"/> Presence/Participation in Treatment	<input type="checkbox"/> Other _____
<input type="checkbox"/> Nursing/Medical Information	

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 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: One year from signing.

Conditions

I further understand that Debbie Schwartz, LICSW, 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: poorly coordinated and incomplete treatment which may lead to termination of services.

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.

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