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AUTHORIZATION FOR RELEASE OF MENTAL HEALTH RECORD (Also known as Protected Health Information)

I, ____, hereby authorize Marina Bommarito LPCC and
(Client or guardian)
____, to exchange information until this date
___________________.

Client ____
The type of information to be disclosed:
o Evaluations
o Medical/Hospital Records
o Diagnosis
o Psychological/Medical Test Results
o Treatment Plan
o Mental Health Record Summary
o Course of Treatment
o Psychotherapy Notes
o Coordination of care
o Other ____
The purpose of such disclosure:
o Ongoing Treatment
o Medical Care
o Consultation
o Evaluation
o Transfer
o Legal issues
o Coordination of Care
o Health Benefit Utilization
o Other ____

Exceptions:____

1. A photocopy of this form will be considered as valid as the original.
2. I understand that I may revoke this authorization at any time by notifying Marina Bommarito, in writing, and this authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it or within one year of authorization.

3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations. However, other state or federal law may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information and mental health information.
4. I understand that my refusal to sign this Authorization will not jeopardize my right to obtain present or future treatment for my mental health except where disclosure of the information is necessary for the treatment.
5. My health care and payment for my health care with Golden Counseling Center will not be affected if I do not sign this form.
6. I understand that I can request a copy of this form after I sign it.

The designated information about me ( ) may ( ) may not be transmitted by fax, electronic mail or other electronic file transfer mechanisms. Lynette Kreidler, M.Ed.,

LPCC and the above designated person ( ) may ( ) may not discuss by telephone the content of the information released.

I hereby release all parties stated herewith from any liability resulting from the release of this information. I agree that a photocopy of this release shall be as valid as the original.
I understand that my communications in therapy are protected under federal and state confidentiality regulations and cannot be disclosed without my written authorization. The information provided by a client during therapy sessions is legally confidential in the case of licensed clinical social workers, except as provided in section 12.43.218 CRS and except for certain legal exceptions. In general, these exceptions pertain to matters of danger to self or others, and to assault or neglect of children.
I further understand that the potential exists for re-disclosure of my private mental health information, and that it may no longer be protected under the HIPAA privacy regulations.
This is to certify that I have given consent freely and voluntarily, and that the benefits and disadvantages of releasing the information, if known, have been explained to me.

Date:___________________________
Signature of Client or Personal Representative ______________________________________

FEDERAL REGULATIONS PROHIBIT THE RECIPIENT OF THIS INFORMATION FROM MAKING ANY FURTHER DISCLOSURES OF THIS INFORMATION.
This authorization to disclose private health information is for the release of psychotherapy notes or purposes other than my treatment, payment or the related operations of the practice, and I understand that my authorization, or refusal, will not affect my ability to get treatment or payment. However, the Practitioner can condition

those things (1) if the my treatment is related to research, or (2) if my treatment is being provided to me solely for the purpose of creating protected health information for disclosure to a third party.

By my signature below, I acknowledge a receipt of this disclosure.

Date: ______________

Signature of Client or Personal Representative ____________________________________

Note: This form may be used for a release of information when HIPAA compliancy is not required but our practice standards are to obtain a written release, by using page one only. The second page (which can be the backside of the first page) makes this a HIPAA treatment, payment, or operations activities. Since psychotherapy notes are so sensitive and enjoy extra protection under HIPAA, it is advisable to use the following form for authorization to release psychotherapy notes. Remember, they must have a separate authorization form, and cannot be included on authorizations to release other information. Compliant authorization for use when the release is to parties and is not related to treatment, payment, or operations activities. Since psychotherapy notes are so sensitive and enjoy extra protection under HIPAA, it is advisable to use the following form for authorization to release psychotherapy notes. Remember, they must have a separate authorization form, and cannot be included on authorizations to release other information.