Authorization to Release Protected Health Information

I, _____, whose Date of Birth is _____,
(Patient/Client Name)

authorize Betsy Giduz, LCSW to disclose to and/or obtain from:_____
(Name of Person or Title of Person or Organization)

the following information:

Description of Information to be Disclosed. (Patient/Client should initial each item to be disclosed.)

_____ Assessment
_____ Diagnosis
_____ Psychosocial Evaluation
_____ Treatment Plan or Summary
_____ Current Treatment Update
_____ Educational Information
_____ Progress in Treatment
_____ Psychotherapy Notes*
(*Cannot be combined with any other disclosure)
_____ Other_____

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 for other purpose, please specify: _____

Revocation. I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Betsy Giduz, LCSW at 107 Ellsworth Place, Chapel Hill, NC 27516. 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 Betsy Giduz, LCSW will not condition my treatment on whether I give authorization for the requested disclosure.

Form of Disclosure. Unless you have specifically requested in writing that the disclosure be made in a certain format, I reserve the right to disclose information as permitted by this authorization in any manner that I 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