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| **Office of Sarah Horvath, LCSW www.drippingspringstherapy.com**  **Consent for Release of Mental Health Treatment Information**    I authorize **Sarah Horvath, LCSW** to disclose and or obtain information about myself or my child or charge  Clients Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Guardians Name if applicable: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Name of person and or place to exchange information with: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    Description of Information to be Disclosed    Initial items to be disclosed:    \_\_\_\_\_ Assessment \_\_\_\_\_ Educational Information  \_\_\_\_\_ Diagnosis \_\_\_\_\_ Discharge/Transfer Summary  \_\_\_\_\_ Psychosocial Evaluation \_\_\_\_\_ Continuing Care Plan  \_\_\_\_\_ Psychological Evaluation \_\_\_\_\_ Progress in Treatment  \_\_\_\_\_ Psychiatric Evaluation \_\_\_\_\_ Demographic Information  \_\_\_\_\_ Treatment Plan or Summary \_\_\_\_\_\_Psychotherapy Notes\*  \_\_\_\_\_ Current Treatment Update (\*Cannot be combined with any other disclosure)  \_\_\_\_\_ Medication Management Information \_\_\_\_\_\_Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_ Presence/Participation in Treatment \_\_\_\_\_\_Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_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.    I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Sarah Horvath, LCSW. 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 1 year from the date of signature.  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 stricter than HIPAA and provides additional privacy protections.  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature of Patient/Client Date    \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature of Parent, Guardian or Personal Representative Date |