Client's Name: _____ Date of Birth: _____
I request and authorize Linda M. Mixon, LCSW to release of behavioral healthcare information for the individual named above. I authorize that information can be: [ ] Disclosed to [ ] Obtained from [ ] Exchanged With
Name: _____ Relationship to Client: _____
Address: _____ City/State/Zip: _____
Phone: _____
Information released is related to treatment for [ ] Mental Health [ ] Alcohol/Substance Abuse

[ ]	Demographic Information	[ ]	Treatment Plan
[ ]	Attendance	[ ]	Progress Notes
[ ]	Progress in Treatment	[ ]	Treatment Summary
[ ]	Assessments	[ ]	Medication Information
[ ]	Diagnoses	[ ]	Dialogue
[ ]	Other:_____		

Information released is for the expressed purpose of:

[ ]	Treatment planning	[ ]	Personal Use
[ ]	Case management	[ ]	Legal Purposes
[ ]	Provide continuity of care	[ ]	Social Security/disability
[ ]	Compliance with treatment recommendations	[ ]	Insurance/Managed Care
[ ]	Other:_____		

Dates of Service:_____ to_____

I understand that my health information is protected under the federal regulations governing the Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2 that re-disclosure is prohibited, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 45 C.F.R. Parts 160 and 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. The information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer will be protected by the HIPAA Privacy Law.

By signing this document I acknowledge that:

1. I have reviewed and understand the Notice of Privacy Practice.
2. I understand this authorization is subject to revocation at any time, except to the extent that action has been taken in reliance on the authorization.
3. I understand the nature of the information that will to be released.
4. I may request restrictions on how my health information is used and disclosed.
5. I have been offered a copy of this authorization and the Notice of Privacy Practices.

**This release is active for one year from date on signature unless otherwise noted: _____

This form has been fully explained and I certify that I understand its contents. I understand that Linda M Mixon, LCSW may not condition treatment on obtaining this consent/authorization from me.

_____Date_____
Participant's Signature or Oral Consent when physically unable to sign
"I understand the nature of the release and freely give oral consent"

_____Date_____
Signature of Authorized Person in lieu of Participant
[ ] Parent/Guardian [ ] Power of Attorney [ ] Specify Other_____

_____Date_____
Oral Consent/Witness Signature

[ ] **Copy Accepted** [ ] **Copy Refused**