SHOMAN CENTER FOR STRESS MANAGEMENT, LLC
Behavioral Health Treatment Release of Information

I, _____[Insert Name of Patient/Client], whose Date of Birth is _____,

authorize Shoman Center for Stress Management, LLC to disclose to and/or obtain from:

_____
the following information: [Insert Name, Address and Telephone Number of Primary Care Physician or Psychiatrist]

Description of Information to be Disclosed

(Patient/Client should initial each item to be disclosed)

_____ Assessment
__X__ Diagnosis
_____ Psychosocial Evaluation
_____ Psychological Evaluation
__X__ Psychiatric Evaluation
__X__ Treatment Plan or Summary
__X__ Current Treatment Update
__X__ Medication Management Information
__X__ Presence/Participation in Treatment
__X__ Nursing/Medical Information

_____ Educational Information
__X__ Discharge/Transfer Summary
__X__ Continuing Care Plan
__X___ Progress in Treatment
_____ Demographic Information
_____Psychotherapy Notes*
(*Cannot be combined with any other disclosure)
_____Other_____
_____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.

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Shoman Center for Stress Management, LLC at 1825 E. Northern Avenue, Suite 135B, Phoenix, AZ 85020. 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: _____

Conditions

I further understand that Shoman Center for Stress Management, LLC 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: None at this time

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