KINDELAN MCDANAL & ASSOCIATES

PSYCHOLOGICAL & COUNSELING SERVICES

4729 US 98 S; SUITE # 104, LAKELAND, FL 33812

OFFICE: (863) 877-1855 FAX: (863) 646-6111 EMAIL: INFO@KINDMCD.COM

AUTHORIZATION FOR RELEASE OR EXCHANGE OF CONFIDENTIAL INFORMATION

Patient's Name: _____ DOB: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

I, _____ hereby give my permission to **KINDELAN MCDANAL & ASSOCIATES** to release or request from a third party information contained in my/my child's medical record. I understand that my/my child's medical record may contain information concerning my/my child's psychiatric, psychological, drug or alcohol abuse, sexual abuse treatment, HIV/Acquired Immune Deficiency Syndrome (AIDS) and/or related conditions, and that under law these records are classified as privileged and confidential and cannot be released to me or those designated by me or my legal guardian without an expressed and informed consent. In addition, I understand that those records will not be released to entities other than those designated by myself or my personal representative or otherwise provided in federal law.

The type of information to be disclosed and/or requested is as follows:

To Be Released from Kindelan McDanal & Associates to the party listed below:	**To Be Requested** from the party listed below:
_____ Treatment Plans	_____ Treatment Plans
_____ Process Notes	_____ Process Notes
_____ Health – Medical Records (if applicable)	_____ Health – Medical Records (if applicable)
_____ Verbal – Email Communication	_____ Verbal – Email Communication
_____ Letter(s) of Progress	_____ Court Documents
_____ Results of Psychological and/or Educational Testing	_____ Academic and/or Educational Records
_____ Bio Psychosocial Evaluation/Assessment (if applicable)	_____ Psychological/Psychiatric Evaluations/Assessments
Other Information – Please Specify: Referral Letter	Other Information – Please Specify: _____

Name/Agency: _____

Address: _____

Phone: _____ Fax: _____

** In the case of notes documenting or analyzing the contents of conversation during a private counseling session ("process notes"), such records may be protected from disclosure under the HIPAA Privacy Rule).*

_____ (initial) I understand that I have the right to withdraw my authorization at any time except to the extent that action has already been taken pursuant to the authorization. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to **KINDELAN MCDANAL & ASSOCIATES.**

_____ (initial) I understand that authorizing the disclosure of this health information is voluntary, I can refuse to sign, and **KINDELAN MCDANAL & ASSOCIATES** will not base my treatment or payment whether or not I provide authorization for the requested use or disclosure. I understand that I may inspect or copy the information to be disclosed, as provided in CFR164.524 (with reasonable charge).

_____ (initial) I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of the information and is no longer protected by federal confidentiality laws or **KINDELAN MCDANAL & ASSOCIATES. KINDELAN MCDANAL & ASSOCIATES** will not be held liable for information disclosed to another party per the client's request.

_____ (initial) I understand that **KINDELAN MCDANAL & ASSOCIATES** will release only the minimum amount of information necessary to fulfill a request.

This authorization shall expire when the client is discharged from the current episode of care (treatment has been completed, the client rejects/declines/drops out of treatment, is referred elsewhere, moves, or in the case of the client's death.) This agreement is subject to revocation in writing at any time.

RELEASE:

_____

Signature Client/Next of Kin/Guardian Date

_____

Relationship to Client

REQUEST:

_____

Signature Client/Next of Kin/Guardian Date

_____

Relationship to Client