LKH Therapy

Live In Balance • Know Your Strengths • Harness Your Power

AUTHORIZATION FOR RELEASE OF MENTAL HEALTH, ALCOHOL &DRUG ABUSE, AND OTHER PERSONAL HEALTH INFORMATION

I, _____authorize **Laura Kezdi-Hamzeloo, LCPC,** to release/exchange any and all
(Patient, Parent/Guardian/Power of Attorney)

Records or information regarding _____
(Name of Patient)

(SPECIFIC NATURE OF INFORMATION TO BE DISCLOSED)

The following items must be checked and initialed to be included in the use and/or disclosure of other health information:

✔ ____ Mental Health information
__ ____ Psychotherapy Notes
__ ____ HIV/AIDS related treatment
__ ____ Drug/alcohol diagnosis, treatment/referral
__ ____ Sexually Transmitted Diseases

To _____
(Receiving Agency/person) (Address)

For the purpose of: (please check all that apply)

___ Continuing (health and mental health) treatment or care and continuity of care
___ Therapist transition
___ Housing and other arrangements and services
___ Billing, Payment and financial matter and arrangements
___Consultation, advise and representation my condition and needs
___ Other _____
_____

This consent is valid until (calendar date)_____
I understand that I have the right to inspect and copy the information to be disclosed and may revoke this authorization at any time. Any such revocation will not affect materials disclosed prior to the revocation. The above-named person authorized to receive this information may use the information only for the purposes outlined above and may not redisclose it without my written authorization.

I understand that if I refuse to consent to this release of information the following may occur _____
_____

_____ _____ _____
(Minor recipient 12-17 yrs. or older) (Signature of adult patient or parent) (Date)

_____ _
(Witness)

NOTICE TO RECEIVING FACILITY/THERAPIST: Under the provisions of the Illinois Mental Health and Developmental Disabilities Confidentiality Act, HIPAA, and applicable Federal and State Alcohol and Substance Abuse Confidentiality Acts, there many not be redisclosure of any of the information provided pursuant to this release unless the patient, and/or parent of the patient who is a minor, specifically authorizes such disclosure. A separate release is required for psychotherapy notes.

_____

REVOCATION OF AUTHORIZATION

The undersigned herby revokes the above authorization for disclosure

_____(Patient, parent, guardian) _____(Witness)

_____(Authorized agent-Power of attorney attached) _____(Date)

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