Authorization to Release Protected Health Information

I, _____whose Date of Birth is _____, authorize Sarah Dawson, LCSW,
[Name of Patient/Client],

to disclose to and/or obtain from: _____, who can be
[Name of Person or Title of Person or Organization]
reached at _____,
[Telephone Number] [Email Address]
the following information:

Description of Information to be Disclosed :

(Please initial each item to be disclosed)

_____ Assessment _____ Diagnosis _____ Psychosocial Evaluation _____ Psychological Evaluation
_____ Psychiatric Evaluation _____ Treatment Plan or Summary _____ Current Treatment Update
_____ Medication Management Information _____ Presence/Participation in Treatment
_____Nursing/Medical Information _____ Educational Information _____ Discharge/Transfer
Summary _____ Continuing Care Plan _____ 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.

If the purpose is other than as specified above please specify:

_____
_____
_____

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Sarah Dawson, LCSW, at 112 Swift Ave., NC 27705. 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: _____ or as otherwise indicated:_____

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Conditions

I further understand that Sarah Dawson, LCSW, 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 consequence of not being able to continue the therapeutic relationship.

_____

_____ _____

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

☐ Check here if patient/client refuses to sign authorization

_____

Signature of Witness Date

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