Be. Counseling Partners

Authorization to Disclose Protected Health Information

1. Client Name (print): _____ Date of Birth: _____

Other Names used: _____Phone: _____

Parent/Guardian/Legal representative: _____

2. I am requesting that health information be **released from** one of the following:

Organization Name/Specific Provider: _____

Address: _____City: _____ State: ____ Zip: _____

Phone: _____Fax: _____

3. I am requesting that health information be **sent to**:

Organization Name/Specific Provider: _____

Address: _____City: _____ State: ____ Zip: _____

Phone: _____Fax: _____

Please indicate the type of information to be released:

_ Documentation from a specific program/provider: _____

_ Intake/Diagnostic Assessment

_ Treatment Plans

_ Individual therapy notes

_Discharge Summaries

_ Other (ongoing verbal communication, testing reports etc) _____

Please indicate the reason for releasing information:

_ Client's request _Discharge/ continuity of care _ Insurance _Legal

_ Other_____

I understand that by signing this form, I am requesting that the health information specified be sent to the third party named in section 3. I may stop this consent at any time by writing to the organization(s), and/or professional(s) named in section 2. If the organization, facility or professional named in section 2 has already released health information based on my consent, my request to stop will not work for that health information. I understand that when the health information specified is sent to the third party named in section 3, the information could be re-disclosed by the third party that receives it and may no longer be protected by federal or state privacy laws. I understand that I can refuse to sign this form and that Be. Counseling Partners will not condition treatment, payment, enrollment or eligibility for benefits. If I choose not to sign this form and the organization named in section 3 is an insurance company, my failure to sign will not impact my treatment; I may not be able to get new or different insurance; and/or I may not be able to get insurance payment for my care. This consent will end one year from the date the form is signed unless I indicate an earlier date or event here: Date _____**I acknowledge that I have read and that I understand this authorization form.**

_____

Client Signature **Parent/Guardian/Legal Representative** **Date**