Authorization to use and disclose protected health information

1. I am completing this form to allow Carroll Counseling Centers the sharing of protected health information about

Printed name: _____ Date of Birth: _____

2. I authorize Carroll Counseling Centers to share the following information:

□ Psychological or psychiatric evaluation(s), reports, assessments, treatment notes, summaries, or other documents with diagnoses, prognoses, recommendations, or testing records, and behavioral observations or checklists completed by any staff member or the patient, or similar documents.

□ Information about how the patient's condition(s) affects or has affected his or he ability to work, and to complete tasks or activities of daily living.

□ Billing records

□ Complete copy of the medical record.

Other: _____

3b. Dates of care included:

From _____ to _____ and From _____ to _____

4. To this person or organization _____

5. The information will be used/disclosed for the following purposes:_____

6. I understand and agree that this Authorization will be valid and in effect until_____ [Enter a date or event upon which this Authorization expires.] I understand that after that date or event, no more of this information can be used or released to the person or organization unless I sign a new Authorization like this one.

7. I understand that I can revoke or cancel this authorization at any time by sending a letter to the Privacy Officer of the organization listed above and which is to supply this information. If I do this, it will prevent any releases after the date it is received but can not change the fact that some information may have been sent or shared before that date.

8. I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from the professional or facility listed in #4, nor will it affect my eligibility for benefits.

9. I understand that I may inspect and have a copy the health information described in this authorization.

10. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations.

11. I understand that this professional or facility will receive compensation for the use or disclosure of my health information. The arrangement has been explained to me and I understand and accept it.

12. I affirm that everything in this form that was not clear to me has been explained and I believe I now understand it all and I have received a copy.

Signature of patient or his or her personal representative _____ Date _____

Printed name of patient or personal representative _____

Description of personal representative's authority_____

I, a mental health professional, have discussed the issues above with the client and/or his personal representative. My observations of his or her behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent

_____ _____ _____

Signature of professional Printed name of professional. Date