

**AUTHORIZATION FOR THE RELEASE AND RECIPEROCAL EXCHANGE
OF PROTECTED HEALTH INFORMATION**

Client Name _____

Date of Birth _____

This form, when completed and signed by you, allows the exchange of protected health information between Matt Case, LPC and the person or agency you designate below. This authorization is not a blanket wavier: it allows for specific information to be shared with specific people for a specific purpose, as indicated by you below.

The purpose of this disclosure is:

To assist with treatment To make a referral To allow for billing

Other: _____

I am authorizing Matt Case, LPC and the person or agency below to share protected health information about me or my child:

Person/Agency _____

Address _____

City/State/Zip _____

Phone: _____ Fax _____

I am authorizing only the following information to be released:

Client

<u>Initials</u>	<u>Information</u>
_____	Psychological and/or psychiatric evaluation and diagnosis
_____	Clinician or case manager treatment plan and/or service notes
_____	Medication information
_____	Verbal exchange regarding client evaluation and treatment
_____	Intake and Discharge Summaries
_____	School attendance record
_____	School conduct information
_____	Education achievement information
_____	Verbal exchange with school personnel regarding client evaluation, treatment
_____	Financial information required for reimbursement
_____	Other: _____

This authorization will remain in effect until _____.

I may revoke this authorization at any time by giving written notice.

This authorization is fully understood and is voluntarily made on my part.

Patient's Signature

or

Parent or legally appointed representative's signature

Date of signature

Relationship

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.