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HIPAA AUTHORIZATION FORM

I, _____, whose date of birth is _____, authorize _____ **Paula L. Marcolin, MS, LPC** _____ to disclose to and/or obtain from _____ the following information:

Description of Information to be Disclosed
(Patient/Client should initial each item to be disclosed.)

____	Assessment	____	Testing Information
____	Diagnosis	____	Educational Information
____	Psychosocial Evaluation	____	Presence/Participation in Treatment
____	Psychological Evaluation	____	Continuing Care Plan
____	Treatment Plan or Summary	____	Progress in Treatment
____	Current Treatment Update	____	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 other purpose, please specify: _____
_____

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to _____ **Paula L. Marcolin, MS, LPC** _____ at the above address. 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 _____, or as otherwise indicated:
_____

Conditions

I further understand that _____ **Paula L. Marcolin, MS, LPC** _____ 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 consequences: **_Continuation of care may_ be hindered.**_____

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 (PHI) 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. Other types of information may be re-disclosed by the recipient of the information in the following circumstances: _____
_____

I will be given a copy of this authorization for my records.

_____

Signature of Client Date

_____

Signature of Parent, Guardian or Personal Representative Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual. Attach appropriate document (power of attorney, temporary orders, healthcare surrogate, etc.)

_____

_____

_____ Check here if client refuses to sign authorization.

_____

Signature of Staff Witness Date