AUTHORIZATION OF DISCLOSURE

Stonestreet Professional Offices
5847 SW 29th Street
Topeka, Kansas 66614
Phone: 785-273-7292 Fax: 785-273-1201

Client Name: _____DOB: _____ SSN: _____

I authorize _____ to: ☐ Disclose To ☐ Receive From ☐Both
(Therapist)

Name:_____ Phone:_____ Fax:_____

Address: _____

City:_____ State:_____ Zip:_____

Information to be Disclosed:

☐ Discharge Summary
☐ Treatment Plan
☐ Psychological Testing
☐ Psychological Evaluations
☐ Family Assessment
☐ Verbal/Written Communication With: _____
☐ Intake Information
☐ Progress Notes
☐ Psychiatric Assessments
☐ School Records
☐ Medication Records
☐ Other:_____

I understand that my drug and/or alcohol treatment records are protected under the Federal Regulations governing Confidentiality and Drug Abuse Patient Records (42 C.F.R. Part 2) and the Health Insurance Portability Act (HIPPA) of 1996 (45 C.F.R., Parts 160 and 164) and cannot be disclosed without written consent unless otherwise provided for by the regulations.
I understand that by signing this authorization, I am allowing the release of my mental behavioral health information. This may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), other communicable diseases, and/or alcohol/drug abuse.

If you wish for Drug/Alcohol Abuse information **NOT** to be released, please sign and date below:
Signature:_____ Date:_____

If you wish for HIV information **NOT** to be released, please sign and date below:
Signature:_____ Date:_____

Purpose of Disclosure:

☐ Evaluation/Treatment Planning ☐ Case Coordination ☐ Legal Proceedings
☐ School Placement or Assessment ☐ At Client's Request ☐ Other (specify):

This authorization becomes effective on _____ and will automatically expire one year from the date of request or sooner as designated. Please specify: _____.

I understand that I have a right to revoke this authorization at any time. I must do so in writing and present my written revocation at the office where I am being seen. I further understand that actions already taken based on this authorization, prior to the revocation, will not be affected.

I understand that I have the right to a copy of this authorization.

I understand that authorizing the disclosure of this protected health information is voluntary in most cases. I can refuse to sign this authorization. I do not need sign this form to assure treatment. But, I will be refused treatment for my refusal to sign if my care is mandatory by corrections or the Juvenile justice System. I understand that I may request to inspect or obtain a copy of my record. I understand that any disclosure of information carries the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. Redisclosure may occur in situations such as if my provider's care is reviewed by a state or federal agency, a court orders the disclosure of information, or if I sue my provider and my provider needs the information to defend himself/herself. If I have questions about disclosure of my protected health information, I can contact the office manager at Stonestreet Professional Offices.

PROHIBITION ON REDISCLOSURE OF ALCOHOL AND/OR DRUG ABUSE TREATMENT INFORMATION RECORDS: This information has been disclosed to you from records where confidentiality is protected by Federal law. Federal regulations (42 C.F.R., Part 2) prohibit you from making further disclosure of it without the specific written authorization of the person to whom it pertains, or as otherwise specified by such regulations. A general authorization for disclosure of medical or other information is NOT sufficient for this purpose.
I have read and understand this form. I am the client listed or am authorized to act on behalf of the client as the client's personal representative. I also permit the disclosures indicated above upon presentation of a photocopy of this authorization.

_____ _____
Signature of Client or Parent/Legal Guardian/Representative Date of Signature

_____ _____
Witness Signature Date of Signature