**AUTHORIZATION TO DISCLOSE HEALTHCARE INFORMATION**

Instructions: Fill in the appropriate information in each applicable section. Sign, date, and return the form. Incomplete forms will be returned to you unprocessed. A separate authorization must be completed for each request.

Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I hereby authorize: \_\_release information \_\_exchange information**

|  |  |
| --- | --- |
| **Name:** Nurturing Strong Roots Counseling | **Name:** |
| **Address:** 24014 W Renwick Rd. Suite 105 | **Address:** |
| Plainfield, IL 60540 |  |
| **Phone:** (773) 547-0800 Fax: (630) 428-0069 | **Phone:** |
| **Email:** [nurturingstrongroots@gmail.com](mailto:nurturingstrongroots@gmail.com) | **Email** |

By signing below, I hereby authorize Mansi Sant, to disclose information contained in the medical and financial record of the client identified above, which includes information that may be stored in a paper and/or other electronic format. However, such notes may contain information on general medical care; alcohol and drug abuse treatment; psychological and social work counseling; human immunodeficiency virus (HIV) or acquired immune deficiency syndrome (AIDS), or AIDS related complex. Including communicable diseases or infections, sexually transmitted diseases, venereal diseases, tuberculosis and hepatitis; demographic information; and treatment received at other health care facilities.

**The following information is requested:**

My entire mental health record

Only those portions pertaining to:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*(Specific provider name and/or dates of treatment*

Authorization for Psychotherapy Notes ONLY (Important: If this authorization is for Psychotherapy Notes, you must not use it as an authorization for any other type of protected health information.)

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**The Purpose or Need for Disclosure:**

Further mental health care  Payment of insurance claim  Legal investigation

Applying for insurance  Vocational rehab, evaluation  Disability determination  At the request of the individual  Other (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This authorization is valid only if received within 60 days of being signed.

**This authorization will expire: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 I may revoke this authorization at any time. Revocations to this authorization must be presented in writing. Revocation will not apply to information disclosed prior to receiving a written revocation.

 I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient, and may no longer be protected by federal and state privacy laws and regulations.

 I understand that Mansi Sant will not condition my treatment, payment, enrollment or eligibility for benefits on whether I provide this authorization.

By signing below I acknowledge that I am aware of the confidential and/or privileged nature of the information being disclosed, and understand the benefits and/or disadvantage of disclosing such information. I hereby release above Clinician, its affiliates and its agent and representatives, (including collection agencies) from all legal liabilities that may result from the release of this information according to this request. I also expressly consent and authorize to be contacted by the phone number provided (cellular or residential) by any type of voice method and by auto-dialer technology for any permissible purpose.

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Client (Age 12-and over) Parental Signature if Client is 17 or younger Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Witness

Notice to Recipient: This authorization provides for a ·release of information about an individual whose confidentiality is protected by federal and state laws and regulation, including the Health Insurance Portability and Accountability Act of 1996 (45 C.F.R. §160-164) as well as 42 C.F.R part 2 and 42 U.S.C. §. §290dd-2, and state confidentiality laws. No information disclosed from this authorization may be re-disclosed without the specific written consent of the individual about whom such information pertains.