PATHWAYS
COUNSELING CENTER

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Authorization To Use and Disclose Protected Health Information

Name _____ Address _____ City _____ State _____ Zip _____

Date of Birth _____ Daytime Phone _____ Previous Name _____

AUTHORIZES: PATHWAYS COUNSELING CENTER and/or: _____
Name of Health Care Provider

TO DISCLOSE TO: _____

Name of Health Care provider/Plan/Other _____

Address _____ Phone _____

_____**Initial here if you authorize the disclosing party and the recipient(s) to mutually exchange the information noted below.**

DATE(S) OF INFORMATION TO BE DISCLOSED: From _____ (month/year) to _____ (month/year) If left blank, information from the past two (2) years will be disclosed.

INFORMATION TO BE DISCLOSED: ☐ **Verbal** ☐ **Written**

- ☐ Alcohol/Drug Abuse Assessment
- ☐ Medication Mgt. Info
- ☐ Psychological or Psychiatric Evaluation/Reports
- ☐ Legal Documents
- ☐ Discharge Summary
- ☐ Initial Mental Health Assessment
- ☐ Outpatient Mental Health/AODA Records
- ☐ School Information
- ☐ Other _____
- ☐ Summary of Medical History
- ☐ Treatment Plan
- ☐ Progress Notes/Updates
- ☐ Insurance/Payment/Finances

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 the purpose is other than as specified above, please specify:

_____

_____

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION: Expiration: Unless sooner revoked, I understand this authorization expires on the following date _____ or 6 months from the date signed. I understand that after that date, no more of this information can be used or released to the person or organization unless I sign a new Authorization like this one. **Right to Inspect or Receive a Copy of the Health Information to Be Used or Disclosed:** I understand that I have the right to inspect or receive a copy (may be provided at a reasonable fee) of the health information I have authorized to be used or disclosed by this authorization form. I understand that if I sign this authorization, I may receive a copy. **Revocation**: I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to David Bedrin or Lynn Dusold at Pathways Counseling Center. 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. **Right to Refuse to Sign this Authorization:** 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 above, nor will it affect my eligibility for benefits. Explanation of Refusal: _____
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 appropriate and consistent with applicable law, including, but not limited to, verbal, electronic, or paper format. **Redisclosure:** I understand that there is the potential that the protected health information 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.

I affirm that everything in this form that was not clear to me has been explained and I believe I understand all of it.

Signature of client or personal representative _____ **Date** _____

☐ **I acknowledge that I received a copy of this completed form.**

I, a member of Pathways Counseling Center, have discussed the issues above with the client and/or their representative. My observations of their 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** _____