Authorization to Use and Disclose Health Information

*Please fill out one of these forms for **each person** on your treatment team*

Client name: ______________________________________SSN: ____________________________ Birth Date:_________________

I, ____________________________________ (Client) authorize Rachael Dekoning a to use and exchange my health information as identified below to:

Name: ____Relationship: THERAPIST

Address:____Telephone:_____________________________

City, State, Zip: ____Fax_____________________________

Email if known: ____

For the following purpose(s): **Continuity of care**

By checking the boxes below, I specifically authorize the use of disclosure of the following health information and/or records, if such information and/or records exist.

□ Medications □ Assessments
□ Treatment Plan □ Billing Information
□ Progress Notes □ Referrals
Discharge Summary □ Provider Discharge □ □ Letter regarding: ____________________________

I understand that my medical and psychiatric records may be protected by federal regulations that may determine the extent and nature of the information which may be disclosed pursuant to this authorization. I do hereby give this authorization to the release of records described above freely and voluntarily, and acknowledge that I am not under any force or duress. I further understand that the provision of psychiatric or medical care or treatment will not be denied by reason of or refusal to sign this consent form.

Except to the extent that action has already been taken in reliance upon this authorization, I understand that I may revoke this authorization at any time by giving written notice to the therapist/dietitian at Renew whom is written on this contract.

Unless revoked earlier, this authorization will NOT expire and will remain in effect in perpetuity unless revoked or a specific date, event or condition for expiration is indicated below:

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Specify date, event, condition upon which this authorization will expire. If no date, event or condition is specified, this authorization will NOT expire.

I also understand that, if the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing my health information under other applicable state or federal laws and regulations.

I further understand that the person(s) I am authorizing to use or disclose my information may receive compensation (either directly or indirectly) for doing so.

Signed this__________day of _________________________, 20_______

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Signature of Client