**Authorization to Release Mental Health Treatment Information**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[Name of Patient/Client], whose Date of Birth is \_\_\_\_\_\_\_\_\_,

authorize Veronica K. Needler, L.C.S.W., to disclose to and/or obtain from:

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

the following information.

Description of Information to be Disclosed

*Please initial each item to be disclosed.*

\_\_\_\_\_\_ Assessment

\_\_\_\_\_\_ Diagnosis

\_\_\_\_\_\_ Psychosocial Evaluation

\_\_\_\_\_\_ Psychological Evaluation

\_\_\_\_\_\_ Psychiatric Evaluation

\_\_\_\_\_\_ Treatment Plan or Summary

\_\_\_\_\_\_ Current Treatment Update

\_\_\_\_\_\_ Medication Management Information

\_\_\_\_\_\_ Presence/Participation in Treatment

\_\_\_\_\_\_\_Nursing/Medical Information

\_\_\_\_\_\_ Educational Information

\_\_\_\_\_\_ Discharge/Transfer Summary

\_\_\_\_\_\_ Continuing Care Plan

\_\_\_\_\_\_ Progress in Treatment

\_\_\_\_\_\_ Demographic Information

\_\_\_\_\_\_\_Psychotherapy Notes\*

(\*Cannot be combined with any other disclosure)

\_\_\_\_\_\_Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Research\_\_\_\_

If the purpose of this disclosure is for research purposes, please check this and identify the current and future research studies as well as whether each research study is conditioned upon execution of this authorization and individual’s ability to opt into each study.

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

*Revocation*

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Veronica K. Needler at 5455 W. 86th Street, Suite 115, Indianapolis, IN 46268. 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 the following date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ or as otherwise indicated:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Conditions*

I further understand that Veronica K. Needler 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Form of Disclosure*

Unless you have specifically requested in writing that the disclosure be made in a certain format, I reserve the right to disclose information as permitted by this authorization in any manner that I 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 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 will be given a copy of this authorization for my records.

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Signature of Patient/Client Date

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Veronica K. Needler, L.C.S.W. Date