Parent/Guardian:_____

Reunification Works, LLC
Michael Alter, LCSW | malter@reunificationworks.com P: 503-819-9861

Authorization for Disclosure of Mental Health Treatment

I, _____ *(Insert Name of Client)*, whose Date of Birth is _____, authorize Michael Alter, LCSW to disclose to and/or obtain from: _____ *(Insert Name of Person or Title of Person or Organization),* (Phone Number _____, Fax _____) the following information:

Description of Information to be Disclosed
Client should 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
_____ 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.

_____

_____

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Michael Alter, LCSW at 503-819-9861. 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 Michael Alter, LCSW 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:

_____

[Insert explanation of the consequences, if any, of not signing this authorization, which will depend on the services being provided.]

Form of Disclosure

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, include, 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 that HIPAA and provides additional privacy protections.

I will be given a copy of this authorization for my records upon request.

Signature of Patient/Client Date

Signature of Patient/Client (Representative) Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.).

Please initial here _____ if patient/client refuses to sign authorization.

Signature of Patient/Client Date