



Authorization Mental Health Treatment

I, _____, whose Date of Birth is _____,

authorize **Replay Counseling Center, LLC** to disclose to and/or obtain from:

_____ the following information:
[Insert Name of Person or Title of Person or Organization]

Description of Information to be Disclosed

(Patient/Client should initial each item to be disclosed)

_____ Assessment	_____ Educational Information
_____ Diagnosis	_____ Discharge/Transfer Summary
_____ Treatment Plan or Summary	_____ Continuing Care Plan
_____ Current Treatment Update	_____ Progress in Treatment
_____ Presence/Participation in Treatment	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.

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to [Insert Name] at [Insert Contact Information]. 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 **Replay Counseling Center, LLC** will not condition my treatment on whether I give authorization for the requested disclosure.

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 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.

Signature of Patient/Client Date

Signature of Parent, Guardian or Personal 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.).

Signature of Staff Witness Date