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AUTHORIZATION FOR DISCLOSURE OF MENTAL HEALTH TREATMENT INFORMATION

Name: _____ Date of Birth: _____

Please initial and check one of the following:

_____ ☐ I authorize _____ ☐ I do not authorize

Mary Alice Mills, Ph.D., LLC to disclose to and/or obtain from:

_____

(Enter name of person or agency)

the following information (client should initial each item to be disclosed below):

_____ Assessment
_____ Diagnosis
_____ Psychosocial Evaluation
_____ Psychological Evaluation
_____ Presence/Participation in Treatment
_____ Treatment Plan or Summary
_____ Current Treatment Update
_____ Discharge/Transfer Summary
_____ Continuing Care Plan
_____ Progress in Treatment
_____ Psychotherapy Notes*
(*Cannot be combined with any other disclosure)
_____ Other_____

Purpose: This information may be used or disclosed in connection with mental health treatment, payment, or healthcare operations. If the purpose is other than as specified above, please specify:

_____

Expiration: Unless sooner revoked, this authorization expires on the following date: _____ or as otherwise indicated: _____

Revocation: I understand that I have a right to revoke this authorization at any time by sending written notification to Mary Alice Mills, Ph.D. 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.

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 verbally, in paper format, or electronically, as we deem appropriate. 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 stricter than HIPAA and provides additional privacy protections.

I will be given a copy of this authorization for my records if requested.

CLIENT SIGNATURE: _____ DATE: _____