Authorization for Release of Patient Behavioral Health Information

I hereby authorize Scott Kampschaefer, LCSW to

\_\_\_\_\_ Disclose to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Person/Entity)

\_\_\_\_\_ Obtain from \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Address)

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(City, State, Zip Code)

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Telephone)

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Fax Number)

My behavioral health information as described below, I understand that this authorization extends to all or any part of the records, which may include treatment for physical and mental illness (except for psychotherapy notes), chemical or alcohol dependency, communicable disease such as Human Immunodeficiency Virus (‘HIV’) and Acquired Immune Deficiency Syndrome (‘AIDS’) test result or diagnoses. I understand that my records may be protected by the Federal Rules for Privacy of Individually Identifiable Health Information )Title 45 of the Code of Federal Regulations, Pats, 160 and 164), the Federal Rules for Confidentiel.ity of Alcohol and Drug Abuse Patient Records (Title 42 of the Code of Federal Regulations, Chapter I, Part 2), and/or state laws, and cannot be disclosed without my written consent ant any time. I understand this consent is subject to revocation at any time, except to the extent that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and payment of my health care will not be affected if I do not sign this form

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Print Patient Name Date of Birth Social Security Number

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Description of information to be released: (Initial all that apply)

\_\_\_ Discharge summary \_\_\_ Progress Notes \_\_\_ Billing/financial Record

\_\_\_ Treatment Plan \_\_\_ Mental Status Exam \_\_\_ Verbal Communication with:

\_\_\_ Consultation reports \_\_\_ Psychological testing \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_(Name)

\_\_\_ Others \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Relationship)

The purpose of the disclosure is for the following: (Initial all that apply)

**Patient Request**:

\_\_\_ Continuity of Care \_\_\_ Personal Information \_\_\_Legal purpose \_\_\_ School

\_\_\_ Insurance \_\_\_ Social security/Disability Benefits

\_\_\_ Other: Please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that if the recipient authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by the federal and state privacy regulations. I understand that the authorization will expire 180 days from the date of this authorization unless I otherwise specify. I desire this authorization to be in effect until \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Signature of client Date Guardian of client Date

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

Witness signature Date Witness last name