Guiding Change Psychotherapy LLC
P.O. Box 52284, Sarasota, FL 34232-0319
Phone: (941) 961-4745

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

CLIENT NAME:_____ Date of Birth:_____

I authorize: William J. Roderick, LCSW (Name) 5049 Ringwood Meadow, Sarasota, FL 34235 (Physical Address)

941-961-4745 (Phone number) to release my information to / to obtain my information from_____ (Circle One)

_____
(Name of Office or Individual) (Address)

_____
(Address Cont.) (Phone number) (Fax number)

PLEASE CHECK INFORMATION TO BE DISCLOSED:
(Client should initial each item to be disclosed)

_____Assessments
_____ Diagnosis
_____Psychological Evaluations
_____Psychiatric Evaluation
_____ Mental Health Progress Notes
_____ Substance Abuse Records
_____ Treatment Plan or Summary
_____ Current Medications
_____ Discharge Summary
_____ Verbal Communication
_____Other_____

PURPOSE OF THIS DISCLOSURE:
(Check all that apply)

_____ Continuity of Care
_____ Coordination of Services
_____ Social Security Benefits
_____ Legal Reasons
____ Other:_____

EXPIRATION

This authorization will expire on _____(date) If I fail to specify expiration date this authorization will expire in one year.

This authorization is prepared pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C. Section 132d, et Seq., and regulations promulgated there under, as amended from time to time (collectively referred to as HIPAA) This authorization affects your rights in the privacy of your personal behavioral health information. Please read it carefully before signing.

I understand that the information in my health record may include information relating to sexually transmitted disease acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information relating about behavioral or mental health service, and treatment for alcohol and drug abuse. Guiding Change Psychotherapy, LLC will not condition treatment on your providing authorization for the requested use or disclosure. You may refuse to sign this authorization. You have the right to revoke this authorization, in writing, at any time, except to the extent that Guiding Change Psychotherapy LLC has taken action in reliance on it.

By signing this authorization I acknowledge and agree that any information used or disclosed pursuant could be at risk of re-disclosure by the recipient and no longer protected under HIPAA.

This information has been disclosed to you from record protected by 42 CR Part 2. The federal Rules prohibit you from making any further disclosure unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFT Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose.

ACKNOWLEDGED AND AGREED TO BY:

_____ _____
Signature of Client Date

_____ _____
Signature of Witness Date

Rev. 01-09-2017