Authorization For Disclosure Of
Mental Health Treatment Information

I, ______________________________, the undersigned, whose Date of Birth is _______,

authorize **Brooke Sears, Psy.D.** to disclose to and/or obtain from:

____

Name

____

Address

____

Phone Number

the following information: (Check all that apply)

_____ 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

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:

____

____

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Brooke Sears at drbrookesears@gmail.com 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:____

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 Client Date

____ _____________________

Signature of Parent or Guardian 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.).

____ Check here if patient/client refuses to sign authorization

____ _____________________

Signature of Staff Witness Date