**Stacey Bruen, MC, NCC, LPC**

9929 North 95th Street, Suite 101 · Scottsdale, AZ 85258 · (480) 948-1123

## Authorization to Release/Exchange Information

Name(s) of Client(s): **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Date of Birth(s): **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby authorize **Stacey Bruen, MC, NCC, LPC**

 ☑ **to release to:** ☑ **to receive from:**

|  |
| --- |
| Name and full address of person/facility: |

**…the specific information indicated below with regard to the services provided to the above named client(s) for the following purpose(s):**

* Coordination of treatment with another mental health professional involved in your care.
* Coordination of treatment with another type of health professional involved in your care.
* To obtain insurance or other third party benefits under a managed care agreement.

 ◻ For processing of my insurance, employee benefits claim or other financial arrangements.

 ◻ Coordination with another type of professional (e.g., attorney, custody evaluation, etc.)

* Other, specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Such disclosure of written or oral conversations shall be limited to the following specific types of information:**

* Assessment, diagnosis, treatment plan, compliance, functionality, test results, and response to treatment.
* Information pertaining to substance abuse or substance dependency.
* Sensitive relationship issues, family dynamics, sexual issues, and other highly personal information.
* Other, specify All Available Information\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Such The specific use of Protected Health Information (PHI) to be discussed or released are as follows:**

* Coordination of response to psychotropic medications prescribed by a psychiatrist, physician, or licensed nurse practitioner.
* Coordination of other medical treatment with mental health, marital, or family treatment.
* Coordination of marital or family treatment with individual treatment.
* Case management and/or utilization review under a managed care agreement.
* Review of treatment and/or functionality to obtain benefits of non-health-insurance related programs.
* Other, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that the information to be released includes records in any form, and oral conversations with Stacey Bruen, MC, NCC, LPC. I understand that I have a right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing. I understand that I have the right to refuse to sign this authorization. I understand that I have the right to revoke this authorization at any time unless Stacey Bruen has taken action in reliance upon it. And, I also understand that such revocation must be in writing and received by Stacey Bruen at the above stated address to be effective.

This authorization shall remain valid until:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (6 month duration)

Client/Patient Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness (if necessary)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_