# Authorization for Disclosure of Protected Health Information

Derfus Counseling Services
1221 Park Place NE, Cedar Rapids, IA 52402
319-936-7008

Client Name _____
Date of Birth _____ Social Security Number _____

I authorize Derfus Counseling Services to disclose to and/or obtain from:

Name: _____ Phone: _____
Address: _____ the following information:

Description of information to be disclosed:

_____ Assessment/Evaluation
_____ Psychological Testing
_____ Psychiatric Testing
_____ Discharge Summary
_____ Medical Information
_____ Progress Notes
_____ Verbal information to review status in treatment and referral
_____ Other _____

Purpose of disclosure of information:

_____ Diagnosis and Treatment
_____ Case Coordination
_____ Legal
_____ Other _____

To be included: _____ Mental Health _____ Substance Abuse _____ HIV/AIDS information

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Derfus Counseling Services. 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.

This consent expires one year after termination of services or as otherwise indicated: _____

I further understand that Derfus Counseling Services will not condition my treatment on whether I give authorization for the requested 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.

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 understand that I may review the disclosed information.

I acknowledge that I have received of copy of the Authorization.

_____
Signature of Patient/Client or Legal Representative 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.). _____

_____
Signature of Witness Date