DENVER BOULDER
COUNSELING

## Authorization For Disclosure Of Mental Health Treatment Information

I, _____[Insert Name of Patient/Client], whose Date of Birth is _____,

authorize Kelly Shaughnessy, LPCC and Denver Boulder Counseling, lllc to disclose to and/or obtain from:

_____

[Insert Name of Person] and/or [Title of Person or Organization]_____

the following information:

**Description of Information to be Disclosed** (Patient/Client should initial each item to be disclosed)

_____ 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* (*Cannot be combined with any other disclosure)

_____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 Kelly Shaughnessy, LPCC at kellydbcounseling@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:_____

## Conditions

I further understand that Denver Boulder Counseling, pllc will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences: _____

_____

## 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 Patient/Client Date

_____

Signature of Parent, Guardian or Personal 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.).

_____Check here if patient/client refuses to sign authorization

_____

Signature of Staff Witness Date