Authorization to Release Confidential Information

(Please complete this form if you would like Ms. Eby to be in contact with your current Therapist, Past Psychiatrist, or other provider.)

Client Name ____DOB________

I ___________________________________hereby authorize Susan S. Eby, APRN

To RECEIVE the Following Information: **Please check the appropriate box(es)**	AND/OR	To DISCLOSE the Following Information: **Please check the appropriate box(es)**
□ Any and all information relating to my care and treatment by the below named provider		□ Any and all information relating to my care and treatment by Susan S. Eby, APRN
Only the following information		**Only the following information**
□ **Demographics**		□ **Demographics**
□ **Assessment**		□ **Assessment**
□ **Progress Notes**		□ **Progress Notes**
□ **Treatment Plan**		□ **Treatment Plan**
□ **Discharge Summary**		□ **Discharge Summary**
□ **Other (specify)**		□ **Other (specify)**

Information to be Received From/Disclosed To:

Name ____Company_______________________

If I have been diagnosed and/or treated for any of the following, I understand that Susan S. Eby needs my explicit consent to disclose information related to the diagnosis or treatment. This information, if applicable, absolutely may not be disclosed without my explicit consent.

□ I DO	□ I DO NOT	Authorize disclosure of information which refers to treatment or diagnosis of drug or alcohol abuse
□ I DO	□ I DO NOT	Authorize disclosure of information which refers to treatment or diagnosis of HIV/AIDS
□ I DO	□ I DO NOT	Authorize disclosure of information which refers to mental health treatment

I authorize the above named provider to make subsequent disclosures to the same recipient pursuant to this authorization. Unless earlier revoked, this consent expires in 90 days or on the following date not to exceed one (1) year. Specified date:____________

I waive my right to review this information prior to its disclosure	□ YES □ NO
I authorize the provider to send/receive these records by fax	□ YES □ NO

I understand that I may refuse to release some or all of the information in the provider's records, but that such refusal may result in improper diagnosis or treatment, denial of coverage or denial of claim for health benefits or insurance, or other adverse results. Susan S. Eby will NOT release health information generated by other providers or facilities. Statements added to records by clients and/or guardians will not be released without written consent. I understand that if the above listed information is disclosed, it is possible that it may be re-disclosed by the recipient, or that it many no longer be subject to confidentiality protections.

I understand the matters discussed on this form. I release Susan S. Eby from any legal responsibility or liability for the disclosures of the above information to the extent indicated and authorized herein.

I understand that I may revoke this authorization at any time by giving written or verbal notice to Susan S. Eby. This will not affect information released prior to receiving my request to revoke.

Client____Date__________________

OR: Authorized Representative_____________________________Date__________________

Relationship to Client__________________________

Witness ____Date__________________

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