AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Client Name: _____ **DOB:** _____ **Social Security Number:** _____

I, _____, hereby authorize and permit CRYSTAL A. McCOMAS, LSCSW, LLC, to use, disclose and/or exchange information with the below named individuals or entities in accordance with the parameters defined in this authorization.

A. Name of Individuals or Entities *(Client should initial next to the Individuals or Entities we may communicate with).*

Parent or Representative	Client	Name of Individual or Entity

B. Description of Information to be Used or Disclosed *(Client should check each item to be disclosed).*

____ Complete Medical Record
____ Assessment
____ Diagnosis
____ Psychosocial Evaluation
____ Psychological Evaluation
____ Psychiatric Evaluation
____ Treatment Plan or Summary
____ Current Treatment Update
____ Medication Management Information
____ Educational Information
____ Discharge/Transfer Summary
____ Continuing Care Plan
____ Progress in Treatment
____ Demographic Information
____ Psychotherapy Notes*
(*Cannot be combined with any other disclosure)
____ Presence/Participation in Treatment
____ Other _____

C. Purpose of Use or Disclosure. (*Client should check or otherwise indicate the purpose of this use or disclosure*).

____ Coordination and Continuity of Care and Services
____ Further Assessment of Treatment Needs
____ School Placement or Assessment
____ Litigation (i.e., Divorce, Personal Injury)
____ Criminal Proceedings (i.e., Diversion, Probation)
____ Other _____

D. Client Acknowledgment.

Right to Revoke. I understand that I have the right to revoke this authorization at any time by sending written notification to CRYSTAL A. McCOMAS, LSCSW, LLC, at 3300 Clinton Parkway Court, Suite #120, Lawrence, Kansas 66047. I further understand that any written revocation I submit to CRYSTAL A. McCOMAS, LSCSW, LLC will be effective from the date of receipt and is not effective to the extent that any person or entity has already acted in reliance on my authorization.

Potential for the Use/Disclosure of Sensitive Information. I understand that my client record may contain sensitive information including, but not limited to: psychiatric disorders and behavioral health treatment, communicable diseases (including but not limited to: HIV/AIDS, Tuberculosis, Hepatitis C, and other Sexually Transmitted Diseases), substance abuse history and substance abuse treatment.

Risk of Re-Disclosure. I understand that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information may no longer be protected by federal confidentiality and privacy regulations in such an event.

Form of Disclosure. I understand that, unless I have specifically requested in writing that the disclosure be made in a certain format, my information may be disclosed in any manner that deemed to be appropriate and consistent with applicable law, including, but not limited to, verbally, in writing, or electronically.

Right to Refuse Authorization. I understand that I am not required to sign this authorization and that the provision of treatment services is in no way conditional upon my signing this authorization.

Expiration. Unless revoked sooner, this authorization will expire on _____. (*Date or event cannot be more than one year from the date this authorization was executed*).

_____ _____
Signature of Client Date — Client's Printed Name

_____ _____
Signature of Parent or Personal Representative Date — Parent or Personal Representative's Printed Name

_____ _____
Relationship to Client/Authority — Signature of Staff Witness Date