

Mary A. Donnelly, MA, LPC, LMHC
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Authorization to Release/Obtain Mental Health Information

Date: _____

Patient Name: _____

Date of Birth: _____ Social Security Number: _____

I hereby authorize **Mary A. Donnelly, MA, LPC, LMHC** to disclose and/or request information to/from, specify name, address, fax number if applicable:

Method of Disclosure: Verbal Written Fax Email
Purpose of Disclosure: Coordination of Care Legal Matter
Other: _____

Information to be Disclosed/Requested:

<input type="checkbox"/> Clinical Assessment	<input type="checkbox"/> Diagnosis
<input type="checkbox"/> Treatment Recommendations	<input type="checkbox"/> Treatment Progress/Discharge
<input type="checkbox"/> Psychiatric/Psychological Evaluation	<input type="checkbox"/> Psychological Testing
<input type="checkbox"/> Medication History/Evaluation	<input type="checkbox"/> Progress Notes
<input type="checkbox"/> Academic Records	<input type="checkbox"/> Court Records/Documents
<input type="checkbox"/> Medical History/Physical	<input type="checkbox"/> Laboratory Results
<input type="checkbox"/> Other: _____	

I expressly authorize information concerning the following to be released:

Drug/alcohol treatment/abuse HIV/AIDS/ARC Mental Health Treatment

Notice to recipients receiving drug/alcohol abuse treatment records:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by the 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol/drug abuse patient.

I understand that this authorization will remain in effect for one year from today's date _____.

I understand that if Mary A. Donnelly, MA, LPC, LMHC is requesting the authorization for her own use, it will not condition the treatment, payment, enrollment in a health plan, or eligibility of benefits on my providing authorization for the requested use of disclosure.

I understand that I may request a copy of this signed authorization. A photocopy of this release is valid to the same extent as an original. I further understand that I may refuse to sign the authorization. Information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal or state law. I understand that I can, at any time, change my decision and revoke my authorization, in writing, for releasing/requesting information as noted on this form.

Client Signature

Date

Legal Representative (If Necessary)

Date

Mary A. Donnelly, MA, LPC, LMHC

Date