Kim Smith Iverson Counseling, LLC-LCSW, CSAT
270-392-4656
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Authorization for Use or Disclosure of Protected Health Information

Client Information:

Client Name: ____ DOB: ____

Client Address: ____

Client Phone Number: ____________________________ Client Email Address: ____

Recipient Information:_____ Disclose to _____ Obtain from In this form: _____ Electronic _____ Verbal _____ Written

I, ____, do hereby authorize *Kim Smith Iverson, LCSW, CSAT* to release a copy of my mental health information to the person or facility below.

Name of person/facility to receive medical information: ____

Address: ____

Phone: ________________________ Email Address:______________________________ Date of Authorization: ________________

Information to be Released: *(Note: Requests for release of psychotherapy notes cannot be combined with any other type of request.)*

□ My entire medical record
□ Psychotherapy Notes ONLY *(Important: If this authorization is for Psychotherapy Notes, you must not use it for an authorization f for any other type of protected health information.*
□ Prognosis (diagnosis, opinion of how treatment will benefit client, general status of case)
□ Services offered and purpose
□ Consultation re: progress or lack of progress on goals, status, and cooperation
☐ Other (Explain):____
____

Purpose for Release of Information:

□ Referral to other services
□ Coordination of care
□ Consultation with Doctor/Mental Health Provider
□ At the request of the individual
□ Other (Explain) ____

This authorization lasts one year after the date you sign it unless you enter a different date or expiration here: _________________. This authorization may be cancelled in writing at any time. A photocopy/fax of this authorization will be treated in the same way as an original. Your signature indicates that you have read and understand this form, and authorize release of your information as described above. I understand that I may refuse to sign this authorization and that refusal to sign will not affect treatment.

I understand that my records are protected under Federal Confidentiality regulations (42 CFR Part 2) published August 10, 1987, and the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C. Section 1320d, et. Seq and cannot be disclosed without my written consent. I understand that my medical record may contain information concerning my psychiatric, psychological, drug or alcohol abuse, HIV/Acquired Immune Deficiency Syndrome (AIDS) and/or related conditions.

Prohibition on Re-disclosure

This information has been disclosed from records protected by Federal Confidentiality rules (42 CFR part 2). The Federal rules prohibit making any further disclosure of this information per Federal Guidelines of 42 CFR part 2. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse client.

__________________________________ __________ __________________________________ __________

(CLIENT SIGNATURE) (DATE) (WITNESS/STAFF SIGNATURE) (DATE)