undividedsoul professional counseling
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AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

_____ _____/_____/_____ _____-_____-_____
Client's Full Name (First, M.I., Last) **DOB (MM/DD/YYYY)** **Social Security Number**

I authorize Undivided Soul LLC to ☐ DISCLOSE information to: ☐ OBTAIN information from:

Name of Person/Organization: _____
Address: _____ **City/State/ZIP:** _____
Phone: _____ **Mobile Phone:** _____ **Fax:** _____

Information to be Released/Obtained:

☐ Biopsychosocial Assessment
☐ Diagnosis / Presenting Issues
☐ Treatment Plans
☐ Treatment Progress / Summary
☐ Medical / Medication History
☐ Evaluations / Assessments
☐ Financial / Insurance / Billing
☐ Dates of Service
☐ Other (specify): _____

This information is to be released for the purpose of:

☐ Continued Treatment / Referral
☐ Treatment Coordination
☐ Verification of Attendance
☐ Benefit Eligibility Determination
☐ Emergency Contact
☐ Other (specify): _____

Treatment Dates Covered by this Request: ☐ All prior and current episodes of care ☐ Limited to the following date(s): _____

I understand that refusal to sign this authorization form will in no way affect my right to obtain present and future treatment, except where disclosure of such communications and records is necessary for treatment. I also understand that I may revoke this authorization at any time by signing the "REVOKE AUTHORIZATION" section below, except to the extent that action has been taken in reliance on it. I further understand that the confidentiality of psychiatric, substance abuse, and HIV/AIDS records are protected under State and Federal Laws and cannot be disclosed without my written authorization unless otherwise provided for by law. The information disclosed by this facility pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by Federal law.

I understand that this authorization is voluntary and that information to be released/obtained may include medical, psychiatric, substance use, and/or HIV/AIDS treatment information unless otherwise specified:

_____

This authorization will expire **12 months** from date specified below, unless cancelled or as specified: _____

AUTHORIZATION: _____ _____
Signature of ☐ Client or ☐ Authorized Legal Representative* **Date**

***If signed by authorized representative, please attach copy of legal appointment and specify representation type:**
☐ Conservator/Guardian ☐ Executor of Estate ☐ Other:_____

REVOKE AUTHORIZATION: _____ _____
Signature of Client/Legal Representative* ***Date***

NOTICE TO RECIPIENT: Confidentiality of psychiatric, drug and/or alcohol abuse and HIV records is required and no information from these specific records shall be transmitted to anyone else without written consent or authorization as provided under Connecticut General Statutes, Chapters 899c and 368x and Federal Regulations 42 CFR 2. These laws prohibit you from making any further disclosure without specific written consent of the person to whom it pertains. A general authorization for the release of information is NOT sufficient for this purpose.