AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Today's Date: _____

Client's Name: _____

Client Identification Number: _____

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that the information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state privacy regulations.

Specific Description of Information to be Released: *Description must identify the information in a specific and meaningful fashion. Examples could include: Complete records, Admission or discharge summaries, Behavioral assessments and/or progress notes, Consultation reports, Communication related to treatment, Psychological or Psychiatric evaluations, Treatment plans, Medications, Legal, Diagnostic evaluations, Education/IEP, Other.**

_____
_____
_____.

Persons/Organizations: *Must be a name or specific identification of the person or class of persons authorized to make or receive the disclosure. Include agency name, address, phone number, and fax number.*

_____
_____
_____.

may exchange information of the client named through verbal, written, or electronic means with:

Melinda Cocolas, MS, LMHP
Healing & Wellness Counseling, LLC
Located near 42nd between Grover and Center Streets
Omaha NE 68105
P: 531-222-6371
F: 877-991-5647

Purpose of Disclosure: *Specific description of each purpose of the use or disclosure. When the individual makes the request and does not provide a purpose, the statement "at the request of the individual" is sufficient. Examples could include: Continuity of care, Further mental health care, Payment of insurance claim, Legal investigation, Applying for insurance, Vocational rehabilitation evaluation, Disability determination, At the request of the individual, Other.*

_____
_____
_____.

Expiration Date: I understand that this authorization shall be in force and effect until _____ (*state the specific (1) expiration date or (2) event triggering the expiration*) at which point the authorization will expire.

Revocation of Authorization: I understand that I may revoke this authorization at any time by sending written notification to the providing organization at Healing & Wellness Counseling, LLC, 11902 Elm Street, Suite 3A, Omaha, NE 68144. I understand that a revocation is not effective to the extent that the providing organization has relied on the authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
Authorization for Marketing: I understand that the authorized use or disclosure will result in a direct or indirect remuneration to the providing organization from a third party. *(This section is only necessary if the authorization is for marketing purposes and involves the direct or indirect remuneration to the covered entity from a third party).*

Conditioning of Authorization: I understand that the providing organization will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits on my provision of an authorization for the requested use or disclosure unless my treatment is related to the research, my health care services are provided solely for the purpose of creating protected health information for disclosure to a third party, or if the authorization is sought for the health plans eligibility or enrollment determination for underwriting purposes.

Client's Signature/Parent if Minor/Guardian:	Date:
Responsible Party's Signature (If Not Same as Client or Parent):	
Description of Responsible Party's Authority to Sign Authorization:	

If this Healing & Wellness Counseling, LLC initiated this authorization, you must receive a copy of the signed authorization.

*HIPAA provides special protections to certain medical records known as "Psychotherapy Notes." All Psychotherapy Notes recorded on any medium (i.e.paper, electronic) by a mental health professional (such as a psychologist or psychiatrist) must be kept by the author and filed separate from the rest of the client's medical records to maintain a higher standard of protection. "Psychotherapy Notes" are defined under HIPAA as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separate from the rest of the individual's medical records. Excluded from the "Psychotherapy Notes" definition are the following: (a) medication prescription and monitoring, (b) counseling session start and stop times, (c) the modalities and frequencies of treatment furnished, (d) the results of clinical tests, and (e) any summary of: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

In order for a health care provider to release "Psychotherapy Notes" to a third party, the client who is the subject of the Psychotherapy Notes must sign this authorization to specifically allow for the release of Psychotherapy Notes. Such authorization must be separate from an authorization to release other medical records.