Integrity
Counseling & Coaching

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AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

I, _____, DOB: _____, SSN: _____
(Client Name)

Hereby authorize Aaron Norton, LMHC / Integrity Counseling, Inc. and the Individual or Agency named below:

_____

_____

_____

To exchange with one another the following information:

☐ Assessments; ☐ History and Physical; ☐ Medication Administration Records; ☐ Treatment Plan;
☐ Progress Notes; ☐ Lab Results; ☐ Drug Test Results; ☐ Psychological/Psychiatric Evaluation;
☐ Discharge Summary & Continuing Care Plan;
☐ Vocational and/or Educational Records; ☐ Other: _____

Purpose for the Disclosure: For Continuity of Care

Optional: I also agree to the disclosure of HIV Testing information and AIDS Diagnosis: _____
Client Initials

Information will be disclosed in writing and/or verbally. **Client initial for FAX approval:** _____
Client initials

I understand that my records are protected under the Federal and State regulations governing the confidentiality and privacy of medical records and protected alcohol and drug abuse health information under 42 C.F.R., Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") 45 C.F.R., Parts 160 and 164 and cannot be disclosed without my written authorization unless otherwise provided by the regulations.

I also understand that I may revoke this authorization in writing at any time except to the extent that action has already been taken in reliance on it, and that in any event this authorization expires automatically after one year, unless otherwise stated below:

Date, event, or condition of expiration: _____

I also hereby release Integrity Counseling & Coaching, Inc. from liability which may arise as a result of information disclosed under an authorization, if such information disclosed is later used to my detriment by the individual or agency named above.

Client Signature: _____ **Date:** _____

Parent/Guardian Signature: _____ **Date:** _____

Witness Signature: _____ **Date:** _____