

# Standard Authorization

I, \_\_\_\_\_, whose Date of Birth is \_\_\_\_\_, authorize Dr. Ann McDaniel LMHC PsyD to disclose to and/or obtain from:

\_\_\_\_\_ the following information:

## **Description of Information to be Disclosed**

(Patient/Client should initial each item to be disclosed)

_____ Assessment	_____ Nursing/Medical Information
_____ Diagnosis	_____ Toxicological Reports/Drug Screens
_____ Psychosocial Evaluation	_____ Educational Information
_____ Psychological Evaluation	_____ Discharge/Transfer Summary
_____ Psychiatric Evaluation	_____ Continuing Care Plan
_____ Treatment Plan or Summary	_____ Progress in Treatment
_____ Current Treatment Update	_____ Demographic Information
_____ Medication Management Information	_____ Other _____
_____ Presence/Participation in Treatment	_____ Other _____

## **Purpose**

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services.

If other purpose, please specify: \_\_\_\_\_

## **Revocation**

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to [Insert Name] at [Insert Contact Information]. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

## **Expiration**

Unless sooner revoked, this consent expires on the following date: \_\_\_\_\_ or as otherwise indicated: \_\_\_\_\_

## **Conditions**

I further understand that Dr. Ann McDaniel will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences: \_\_\_\_\_

## **Form of Disclosure**

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

## **Redislosure**

Federal law prohibits the person or organization to whom disclosure is made from making any further disclosure of substance abuse treatment information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. Other types of information may be re-disclosed by the recipient of the information in the following circumstances: \_\_\_\_\_

I will be given a copy of this authorization for my records.

\_\_\_\_\_  
Signature of Patient/Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent, Guardian or Personal Representative

\_\_\_\_\_  
Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.).

\_\_\_\_\_ Check here if patient/client refuses to sign authorization

\_\_\_\_\_  
Signature of Staff Witness

\_\_\_\_\_  
Date