Print, complete, and return to Marcia Brubeck right away

Marcia E. Brubeck, LLC

114 Somerset Street, West Hartford, CT 06110 • Fax (860) 231-1960

Authorization for Information Regarding Mental Health Treatment

I, _____, the Client, Date of Birth _____, authorize Marcia E. Brubeck, LLC, to disclose to and/or obtain from:

_____ the following information:

[Insert Name of Person or Title of Person or Organization]

_____ Assessment
_____ Diagnosis
_____ Psychosocial Evaluation
_____ Psychological Evaluation
_____ Psychiatric Evaluation
_____ Treatment Plan or Summary
_____ Current Treatment Update
_____ Medication Management Information
_____ Presence/Participation in Treatment
_____Nursing/Medical Information

_____ Educational Information
_____ Discharge/Transfer Summary
_____ Continuing Care Plan
_____ Progress in Treatment
_____ Demographic Information
_____Psychotherapy Notes*
(*Cannot be combined with any other disclosure)
_____Other_____
_____Other_____

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.

Marcia E. Brubeck, LLC, hereby declares that the purpose does not and will not include marketing, sale of information, or research.

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Marcia E. Brubeck, LLC, 114 Somerset Street, West Hartford, CT 06110. 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.

Unless sooner revoked, this authorization expires on the following date: _____ or one year from the date of signing.

I further understand that Marcia E. Brubeck, LLC 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:

-- None --

_____

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.

I understand that the protected health information disclosed pursuant to this authorization could possibly be redisclosed by the recipient and that the protected health information will then no longer be protected by the HIPAA privacy regulations unless a state law applies that is stricter than HIPAA and provides additional privacy protections. I hereby affirm that I have received a copy of this authorization for my records.

_____

Signature of Patient/Client Date

_____

Signature of Parent, Guardian, or Personal Representative (indicate if power of attorney, health care surrogate, etc.) Date

_____Check here if patient/client refuses to sign authorization

_____

Signature of Staff Witness Date