BLUE STONE COUNSELING LLC
10218 N. PORT WASHINGTON RD.
MEQUON, WI 53092
(414) 375-9273
www.BlueStoneCounselingLLC.com

For Disclosure Of Mental Health Treatment Information

I, _____[Name of Patient/Client], Date of Birth _____,

authorize Blue Stone Counseling/Susan Miller, LPC to disclose to and/or obtain from:

_____

(Name of Person or Title of Person or Organization)

the following information:

Description of Information to be Disclosed

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

_____ 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

For the Purpose

_____ Educational Information

_____ Discharge/Transfer Summary

_____ Continuing Care Plan

_____ Progress in Treatment

_____ Demographic Information

_____Psychotherapy Notes

This information may be used or disclosed in connection with mental health treatment, payment, or healthcare operations.

If the purpose is other than as specified above, please specify:

_____

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Susan Miller at Blue Stone Counseling. 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 authorization expires on the following date: _____

Conditions

I further understand that Blue Stone Counseling 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:_____

[Insert an explanation of the consequences, if any, of not signing this authorization].

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.

Redisclosure

I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections.

I can print or request 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 Susan K Miller, Blue Stone Counseling