THE THERAPY CENTER FOR WELLNESS & RECOVERY LLP

AUTHORIZATION TO USE AND DISCLOSE INFORMATION

Name _____ Date of Birth_____

Address _____

City/State _____ Zip Code _____

I hereby authorize the provider to use and disclose the information indicated below to:

Name _____

Address _____

Phone _____ Fax_____

Information may be: Mailed Reviewed Only Picked up by: _____

Information to be used and disclosed (circle all that apply):

From and to dates Assessment Diagnosis Psychological Evaluation Treatment Plan

Personal identifying information Current Treatment Update Presence/Participation

Discharge Summary Continuing Care Plan Progress in treatment Billing and Payment info

Demographic information Other _____

I understand that information to be used and disclosed may include protected health information, HIV-related information, and/or information relating to diagnosis or treatment of mental health and/or substance abuse and that by signing this authorization, I am authorizing the use and disclosure of information relating to (circle all that apply):

Substance abuse Mental Health treatment HIV related information

Purpose for the use and disclosure (circle all that apply)

Changing provider Second opinion Continuing Care Legal Personal Insurance

Worker's Compensation School Payment Other_____

I understand and agree as follows:

a. This Authorization will expire in 6 months from my last day of service provided by the Provider. I may shorten, extend, or revoke this Authorization at any time ny notifying the Provider in writing at 4511 Miller Rd, Flint MI 48507, which will be effective on the date the notice is received except to the extent action taken in reliance upon this Authorization.
b. If I am receiving treatment related to mental health or substance abuse, I authorize the provider (i) to use information maintained by Kathryn Karanja, LMSW, CAADC,ADS Kelly Palmer-Albin LMSW,ADS Marie Putnam LMSW The Therapy Center for Wellness and Recovery LLP, to obtain payment for services rendered and (ii) to use and disclose my information, including but not limited to my protected health information, to obtain payment from such entitles for services rendered; and
c. I have received a copy of this Authorization after I signed it or refused to sign it. A photocopy of this Authorization will be considered as valid as the original.

Signature _____
Date _____

Signature of Parent or Guardian_____
Date _____

_____ **Check here if Authorization was not given**

The Provider will not condition treatment or payment on this Authorization. Information disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and no longer protected by applicable law, rule, or regulation.

Prohibition on Redisclosure:

This information has been disclosed to you from records protected by Federal Confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.