Pinellas: 3840 5TH Ave N Saint Pete FL 33713 **Phone:** 727-367-2273 **Fax:** 727-800-6929 **Pasco:** 7340 Little Rd New Port Richie FL 34654

CONSENT TO DISCLOSE HEALTH INFORMATION

For Disclosure Of Mental Health Treatment Information I, ______________________________[Insert Name of Patient/Client], whose Date of Birth is ________, authorize **Caring Community Counseling** 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	_____ Treatment Plan	_____ Continuing Care Plan
_____Diagnosis	_____ Medication Management	_____ Progress in Treatment
_____Psychosocial Evaluation	_____ Participation Treatment	______Psychotherapy Notes
_____ Psychological Evaluation	_____ Educational Information	______Other_______________
_____ Psychiatric Evaluation	_____ Discharge/Transfer	________ ______

I understand that information released may include medical, mental health, and/or drug and alcohol information. I understand that my mental health treatment records are protected under the Federal regulations governing Confidentiality and Drug Abuse Patient Records, 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 consent unless otherwise provided for by the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it before I revoked it. A photocopy or facsimile of this consent is as valid as the original. I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations. I will not be denied services if I refuse to consent to a disclosure for other purposes. At my request, a copy of this form will be provided to me. (Additionally, I acknowledge that any fees incurred by Caring Community Counseling because of this request are my responsibility and will be billed to me.)

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

____
Signature of Staff Witness Date

_____Check here if patient/client refuses to sign authorization

____
Signature of Patient/Client Date