**CONSENT FOR RELEASE OF CONFIDENTIAL MENTAL HEALTH INFORMATION**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I authorize the use or disclosure of my health information as described below:**

1. The following individuals or organizations are authorized to make the disclosure:

**Diamond State Counseling, LLC**

1. The type of information to be used or disclosed is as follows:

**Clinical assessment, diagnosis, progress in treatment**

1. I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. My record may include copies of records from other facilities that have been used in my care.
2. This information may be disclosed to and used by the following individual or organization:

**Name of Organization: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**City, State, Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. This information is being disclosed for the purpose of:

**Receiving clinical information necessary for psychiatry services**

1. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke the authorization, I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization.
2. Unless otherwise revoked, this authorization will expire in 6 months from date signed.
3. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign the authorization. I do not need to sign this release in order to be assured treatment. I understand that I may inspect or copy the information disclosed as provided in C.F.R. 164.524. I understand that any disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about the disclosure of my health information, I can contact the health care provider’s privacy officer.
4. This release of information demonstrates compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), 45 C.F.R.pts160 and 164, and all federal regulations and interpretive guidelines promulgated there under. Once the requested Personal Health Information (PHI) is disclosed, the recipient may re-disclose it therefore the privacy regulations may no longer protect it.

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Patient or Guardian Signature Date