Kim England, LCSW
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HIPAA AUTHORIZATION FORM

To: _____

Client(s): _____ DOB: _____

_____ DOB: _____

_____ DOB: _____

_____ DOB: _____

I, the undersigned, hereby authorize and request Alliance Counseling and Education Center to disclose to and/or, acting on my behalf, obtain from the above-named person or organization any and all records and information about the above client(s) in the following areas:

□ **All health information**	□ Admission summaries	□ Police records
□ Dental care	□ Social histories	□ CPS records
□ School information	□ Treatment summaries	□ Probation/parole information
□ Day care information	□ Discharge summaries	□ Other: Verbal communications

Your initials are required to release the following information:

___ Mental health records (excluding psychotherapy notes)

___ Psychotherapy notes (cannot be combined with any other disclosure)

___ HIV/AIDS test results/treatment

___ Genetic information (including test results)

___ Drug, alcohol, or substance abuse records (including those covered under 42 CFR part 2)

The person signing this form will be responsible for any fees incurred from this request.

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. I understand that if I am currently or become involved in a court related service that this information may be used in court. It may be forwarded to the District Court and will be available to the attorneys of record and to parties to who represent themselves. Information may be further released or disclosed by the court, attorneys, and/or the parties involved. If other purpose, please specify: _____

The purpose of this disclosure of information is for completion of a court ordered evaluation. It may be forwarded to the District Court and will be available to the attorneys of record and to parties to who represent themselves. I understand information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected by HIPAA privacy regulations. Federal law prohibits the person or organization to whom disclosure is made from making any further disclosure of substance abuse treatment information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. Other types of information may be re-disclosed by the recipient of the information in the following circumstances: I consent to re-disclosure of any information protected by 42 CFR part 2. I understand services, treatment, or payment cannot be conditioned on signing this authorization.

I acknowledge that this authorization may be revoked via written notice at any time by sending written notification to Kim England, LCSW at the above address. I understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization. This release is effective until completion of the case unless otherwise revoked. A copy or fax of this authorization is as valid as the original. Dates of service include the entire lifetimes(s) of the above named persons(s). I acknowledge I have read this form, agree to the uses and disclosures of the information described, and was offered a copy of this authorization for my records.

		Self/Parent	
Signature	Printed Name	Relationship to client(s)	Date