PETER LEAR

Psychotherapist

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Name: _____ Date of Birth: _____

I authorize that between Peter Lear, MA, LCSW, RYT, and

Name: _____ Relationship to Client: _____

Address: _____ Phone: _____

_____ Fax: _____

the following information may be exchanged:

____ Clinical progress notes
____ Diagnosis
____ Discharge information
____ Drug and/or alcohol treatment information
____ General case information
____ HIV/AIDS information
____ Intake information
____ Psychiatric evaluation/notes/medications
____ Psychological evaluation
____ Other (specify) _____
_____

The purpose of the disclosure is: _____

I understand that the information disclosed pursuant to this authorization may include information relating to sexually transmitted disease, HIV/AIDS, treatment for alcohol and drug abuse (protected by Federal Law, 42 CFR, Part 2), and psychological or psychiatric conditions unless restricted as follows: _____
_____

Once information is disclosed pursuant to this signed authorization I understand that the general Federal privacy law (45 CFR, Parts 160 and 164) protecting health information may not apply to the recipient of this information and, therefore, may not prohibit the recipient from re-disclosing it.

I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. To revoke this authorization with respect to information other than drug and alcohol treatment program records, I understand that I must provide written notice to release the above parties from liability that may result from furnishing this information. A copy of this release/authorization may be utilized with the same effectiveness as the original.

I understand that I may refuse to sign this authorization, and this will not affect my ability to receive treatment at Labyrinth.

Labyrinth does not recommend email as a means of communication for matters other than scheduling. There is some risk that any protected health information (PHI) that may be contained in such email may be disclosed to, or intercepted by, unauthorized third parties. By signing this form, you are acknowledging that email is not secure and you are releasing Labyrinth from any liability relating to unauthorized disclosure of PHI contained in email correspondence.

Charges for copies: $16.50 for 1-10 pages; $0.75 for pages 11-40; $0.50 for each additional page.

_____ _____

Signature of client, parent/guardian (for client under 15 years of age), or authorized representative, including your authority to act for client

Date

_____ _____

Signature and date to extend request

Signature and date to extend request

NOTICE TO RECIPIENTS OF DRUG AND ALCOHOL TREATMENT PROGRAM INFORMATION: This information has been disclosed to you from records protected by Federal Law (42 CFR, Part 2). The Federal rules prohibit you from making further disclosure of this information unless further disclosure is expressly permitted by 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.