WATER'S EDGE
PSYCHOTHERAPY & WELLNESS CENTER

47 Maple Street, Suite 303
Burlington VT 05401
802-861-3716

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I _____, on behalf of _____ hereby authorize
(Name of client or representative; i.e. parent/guardian) (If applicable, write minor's name or write 'myself')
_____ to: __ Request & receive the following indicated pertinent & relevant information;
(Name of Provider) __ Disclose or release the following indicated pertinent & relevant information;

To/From: _____
(Name of program/agency provider)

___History of psychiatric treatment	___Intake summary/assessment	___Attendance records only
___Psychological evaluations	___Mental health evaluations	___Progress notes
___Substance use/abuse history	___Diagnostic summary and diagnoses	___Course and results of treatment
___Social/family history	___Demographic information	___My mental health record in this entity
___Legal history	___Presence/progress in treatment	___Other: _____

___ I understand that the information released may include information pertaining to substance abuse and/or dependence.
___ I understand that the information released may include information pertaining to HIV infection AIDS or tests for HIV.

The purpose of the disclosure authorized by this consent is:

_____

_____

I understand that my behavioral health records are protected under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. parts 160 & 164 and cannot be disclosed or further re-disclosed by the designated recipient of this information unless expressly permitted by the written consent of the person to whom it pertains, or unless otherwise provided for in the regulations. I also understand that my behavioral health records are confidential and protected from unauthorized disclosure. I understand that if the person or entity that receives this information is not a health plan or health care provider covered by federal privacy regulations, the released information may be re-disclosed by the recipient and many no longer be protected by federal/state law.
I understand that I may revoke this authorization/consent at any time by notifying the provider in writing, except to the extent that action has been taken in reliance on it. Thus, I understand that my revocation will not affect any actions taken by my provider before receiving my written revocation.

This consent/authorization shall be valid for on year from the date below and shall expire one (1) year from the Date of Signature below or upon the *date, event, or condition* noted here, or unless sooner revoked in writing: _____.

I have not been coerced to sign this authorization. I understand that I might be denied services if I refuse to consent to a disclosure for the purpose of treatment, payment, or health care operations, if permitted by state law. I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits nor will I be denied services if I refuse to consent to a disclosure for other purposes. I understand that prepayment for copies of my records as well as payment for services rendered may be required for copies of my record when released to anyone other than a medical provider, facility or institution.

I understand that by signing this form I am confirming my authorization for use and/or disclosure of the protected health information described above with the people and/or organizations named above. I have read this release and understand its contents. I have also been provided a copy of this form.

_____	_____	_____	_____
Print Name of Client	Signature of Client	Date of Birth	Today's Date

_____	_____	_____
Signature of Parent/Guardian	Relationship to Client	Today's Date