SYNERGISM COUNSELING

Authorization To Use and Disclose Protected Health Information (PHI)

ALL fields are required to be completed.

Client Name: _____ DOB: _____

Address: _____ Phone: ____ - ____ - _____

City: _____State: _____ Zip: _____

Synergism Counseling follows federal and state confidentiality regulations prohibiting release of information about you without your permission or as otherwise permitted or required by law. Substance Abuse (SUD) treatment records have additional privacy protections (42 CFR Part 2). I understand that the use and disclosure means sharing of my medical records including verbal, written and electronic communications. I give permission for Synergism Counseling and the person/organization listed below to share my medical, mental health, behavioral health and/or substance abuse treatment records. Synergism Counseling does not re-disclose PHI received from 3rd party providers, entities and/or agencies, except where required by law.

NAME OR OTHER SPECIFIC IDENTIFCATION OF THE AGENCY OR PERSON AUTHORIZED TO RECEIVE/ MAKE THE REQUESTED USE OR DISCLOSURE:

Agency/Name: _____ Attn: _____

Address: _____Phone: _____ - _____ - _____

City: _____State: ____ Zip: _____ Fax No: _____ - _____ - _____

Email: _____

PURPOSE: Please mark the reason the information is to be used or disclosed: 2-Way Verbal Communication is authorized upon signing this release form. (mark all that apply)

___ Coordination of Care
___ Legal/Court
___ Court Order Tx.
___ Probation
___ Personal/Family
___ School
___ Benefits Eligibility/Coord.
___ Short/Long Term Disability
___ Billing/Payments
___Other: _____

EXPIRATION:

___ One-time disclosure ___ Six months ___ End of Treatment

IF no option is marked this authorization will expire 1 year from date signed.

DESCRIPTION OF INFORMATION TO BE USED OR DISCLOSED: (mark all that apply)

___ All Records
___ Assessment/Diagnosis
___ Psychological Evaluation
___ Demographic Information
___ Treatment Plans
___ Psychotherapy Notes
___ Group Notes
___ Continuing Care Plan
___ Medication Mgmt. Info.
___ Presence/Participation in Treatment
___ Progress in Treatment
___ Discharge/Referral Summary
___ Billing

Other: _____

NOTICE TO CLIENT: Signing this form is voluntary and not required to receive services with Synergism Counseling. I understand I may revoke this authorization at any time. To revoke this authorization, I will complete and submit a written Letter of Revocation (the form is available at www.helpfulforms.info). Verbal revocation can be honored for drug and/or alcohol treatment records only. If I am court ordered and end this authorization, I understand this will affect my standing with the courts and the courts will be notified of my revocation. Revocation will not include any information already shared in reliance upon this authorization. I understand that any disclosure of this information has the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. I understand that my health information is protected under the federal regulations governing the Confidentiality of Alcohol and Drug Abuse (SUD) Patient Records, 42 C.F.R. Part 2 that re-disclosure is prohibited, 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 in the regulations. If this is for a minor in a Substance Abuse Treatment (SUD) program, both minor and parent/ guardian must sign the form. A step-parent cannot sign this form without notarized written consent from the legal/custodial parent of the minor client. “Foster Parent” is not the legal guardian and cannot sign this form. The request can take 30+ days to complete and charges will apply.

ACCESS TO MY RECORD: I understand I can request a copy of my record. My provider(s) will review my request and the request can be denied if the records are found to be detrimental to myself, my treatment or others. I understand I can make an appointment with my provider(s) to discuss this decision and review my records by making an appointment. The request can take 30+ days to complete and charges will apply.

By signing this form, I have read and accept all parts of this form.

Client Signature ►_____Date ►_____

Representative Signature ► _____Date ► _____

Representative Name (print) _____Relationship ►_____

Witness Signature ► _____Date ►_____

SYNERGISM COUNSELING MEDICAL RECORDS CONTACT INFORMATION

Address: PO BOX 1292, MIDWAY, UT 84049, Phone# 801-350-1671 Fax: 801-446-6511

I request a copy of this form for my records: _____ Yes _____ No