Authorization for the Release of Protected Health Information

Client Name:_____ Date of Birth _____

Responsible Party Name (if client is a minor):_____

I hereby authorize Brad Fittes, LPCC with Launch Point Counseling LLC AND

Name_____ Title_____

Organization _____

Address _____

Phone_____ Email _____

Relationship to client _____

TO DISCLOSE TO AND COMMUNICATE TO ONE ANOTHER information contained in my client records, including if any, alcohol and drug abuse records, HIV/AIDS tests results or diagnosis, mental health treatment and diagnosis records, and communications made by me to licensed medical and mental health professionals protected under the regulations in 42 Code of Federal Regulations, Par 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA);

SPECIFIC INFORMATION TO BE DISCLOSED

☐ADMISSION/DISCHARGE DATA SET	☐EDUCATIONAL RECORDS
☐ASSESSMENT	☐LAB RESULTS
☐BILLING/DOCUMENTATION FOR INSURANCE	☐MEDICATION MANAGEMENT
☐CONTINUING CARE PLAN	☐PARTICIPATION IN TREATMENT
☐CONTINUING CARE PLAN	☐PROGRESS IN TREATMENT
☐DEMOGRAPHIC INFORMATION	☐PSYCHOLOGICAL EVALUATION
☐DIAGNOSIS	☐TREATMENT PLAN/CONTRACT
☐DISCHARGE SUMMARY	☐TREATMENT UPDATE

PURPOSE AND NEED FOR SUCH DISCLOSURE

I understand that my medical record may contain reports, test results and notes that only a care provider can interpret. I understand and have been advised that I should contact my care provider regarding the entries made in my medical record to prevent my misunderstanding of the information that has been written in the record. I will not hold Launch Point Counseling LLC, or counselors liable for any misinterpretation of the information in my medical record as a result of not having consulted my care provider for the correct interpretation. I understand that generally my treatment may not be conditioned on whether or not I sign an authorization form, but that in certain limited circumstances I may be denied treatment if I do not sign an authorization form.

REVOCATION

This authorization is subject to a written revocation at any time except in those circumstances in which the counseling center has taken certain actions in reliance on such authorization. However, this authorization shall be valid no longer than is reasonably necessary to accomplish the purpose of the actions for which it was given. This authorization will automatically expire 12 months from the end of involvement in our programs or as specified in the revocation below.

This authorization is revoked for the following specified dates, events, or conditions.

Date:_____Event:_____ Condition:_____

CONDITIONS

I understand that Launch Point Counseling LLC Services will not condition treatment, payment, enrollment or eligibility for benefits on the execution of this authorization. If the person/entity that received the above PHI is not a health care provider/health plan covered by federal privacy regulations, the PHI described above may be re-disclosed by such person/entity and will likely no longer be protected by the federal privacy regulations.

FORMS OF DISCLOSURE

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner we deem to be appropriate and consistent with applicable law, including, but no limited to, verbally, in paper format or electronically.

Client (or Responsible Party) Signature

Printed Name	Signature	Date

Your signature signifies that you have received a copy of the "Counseling Agreement, Policies and Consent*" for your records.*

Name of Minor Child

Printed Name	Date of Birth	Date

_____

Witness – **Brad Fittes, MA, LPCC** Date

This authorization was designed to comply with the applicable requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPPA), as well as with state insurance and other federal and state laws governing the use of authorizations and protected confidential health information.