Kootenai Counseling center

PO Box 3324
Post Falls, ID 83877
Phone (800) 395-1159
Fax (800) 826-5412

Client name: _____ Insurance name _____
DOB: _____

Authorization for use and disclosure of protected Health Information

I authorize the use, disclosure and/or exchange of my protected health information to (name of facility you are requesting information from. i.e. hospital, school, another therapist):
Name:_____
Address:_____
Phone:_____ Fax: _____

Reason for the information to be released: _____

I understand that the information in my medical record may include information relating to treatment of drug or alcohol abuse, sickle cell anemia, psychological or psychiatric impairments, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), AIDS related complex (ARC) and/or human immunodeficiency virus (HIV).I consent to the release of information or records created by or disclosed to Kootenai Counseling Center pertaining to:

****INITIAL ON THE LINES**

____Crisis Plan _____Medications _____Discharge Summary _____Psychological summary_____Guardianship paperwork

_____Treatment plans _____Psychological evaluations/Assessments _____Written & verbal communication pertinent to treatment.

Other (please be specific) _____

This for implements the requirements for consumer authorization to use, disclose and exchange health information protected by the federal health privacy law (45 C.F.R parts 160, 164), the federal drug and alcohol confidentiality law (42 C.F.R part 2), and state confidentiality law governing mental health, developmental disabilities, and substance use services. Once information is disclosed pursuant to this signed authorization, I understand that the federal health privacy law (45 C.F.R. Part 164) protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from redisclosing it. Other laws, however, may prohibit redisclosure. When this agency discloses mental health and developmental disabilities information protected by state law or substance abuse treatment information protected by federal law (42 C.F.R. Part 2), we must inform the recipient of the information that redisclosure in prohibited except as permitted or required by these two laws.

I understand that I may refuse to sign this authorization form. Refusal to sign will not be a condition to obtain treatment, payment for or coverage of services, or eligibility for benefits or enrollment,

I understand that, with certain exceptions, I have the right to revoke this authorization at anytime. If I revoke this authorization, I must do so in writing. I understand that the revocation will not apply to the information that has already been released in response to this authorization.
Administrative Use Only ***Note: This authorization to use and disclose information was revoked on_____(date)
I have the opportunity to read and consider the contents of this authorization. I confirm that the contents are consistent with my direction and a copy of this form is as valid as the original to allow release of my records.

This authorization expires on _____, not to exceed one year of the signature.
Signature of Client _____ Date: _____
Signature of legally responsible person: _____ Date: _____
Therapist signature _____Date: _____