Laurie Furman, MS, MSW, LCSW
Furman Family Counseling, LLC

11715 Administration Drive, Suite 101
Maryland Heights, MO 63146
(314) 993-7616

AUTHORIZATION AND CONSENT TO RELEASE/RECEIVE MEDICAL INFORMATION

Patient Name: _____ Birthdate: _____

Address: _____ SS#: XXX-XX-_____

Dates of treatment to release: ☐ All ☐ Specific Dates: _____

I hereby authorize _____ and its employees, agents, or consultants to:

□ Disclose information to □ Obtain information from □ Exchange information with

Name: _____ Relationship: _____

Company: _____

Address: City: _____ ST: _____ Zip: _____

Phone Number: _____ Fax: _____

This information is to be released for the purpose of _____

(Medical records, including psychiatric, psychological and mental health records, frequently contain confidential remarks furnished by the patient, patient's family and staff. If, in the judgment of the medical staff, disclosure of such information will be harmful to the patient, release of such information may be withheld)

I understand this communication may reveal the patient's presence as a patient in a treatment facility. This authorization allows for disclosure of:

☐ Inpatient or outpatient treatment records for physical and/or psychological, psychiatric, or emotional illness or drug or alcohol abuse.

Date(s) of inpatient admission: _____
Date(s) of outpatient treatment: _____
Other identifying information about the service rendered: _____

☐ Psychological evaluation(s) or testing records, and behavioral observations or checklists completed by any staff member or by the patient.

☐ Treatment plans, recovery plans, aftercare plans.

☐ Admission and/or discharge summaries.

☐ Social histories, assessments with diagnoses, prognoses, recommendations, and all similar documents.

☐ Information about how the patient's condition affects or has affected his or her ability to complete tasks, activities of daily living, or ability to work.

☐ Workshop reports and other vocational evaluations and reports.

☐ Billing records.

☐ Academic or educational records

☐ Report of teachers' observations.

☐ Achievement and other tests' results

☐ A letter containing dates of treatment(s) and a summary of progress.

☐ HIV-related information and drug and alcohol information contained in these records will be released under this consent unless indicated here: _____Do not release.

☐ Other: _____
_____

This Authorization and Consent demonstrates compliance with the Health Insurance Portability and Accountability Act ("HIPAA") Standards for Privacy of Individually Identifiable Health Information ("Privacy Standards"), 45 CFR 160 & 164 and Federal Regulations 42 CFR Part 2 and all federal regulations and interpretive guidelines promulgated thereunder. The recipient of this information may not disclose this information unless another authorization is obtained from the patient or unless such disclosure is required or permitted by law (42 CFR Part 2). I understand once the requested information is disclosed, the HIPAA Privacy Regulations may no longer protect it should the recipient re-disclose it.

I understand that my health care provider generally may not condition health care services upon my signing an authorization unless the health care services are provided to me for the purpose of creating health information for a third party.

I agree that a photostatic copy of this form is acceptable.

I understand that I may revoke this Authorization in writing at any time, except to the extent that action has been taken in reliance thereon. In any event, upon fulfillment of the above-stated purpose, this document will automatically expire:

☐ 90 days ☐ 180 days ☐ one year ☐ other_____ from the date signed.

Patient Signature:_____ Date:_____

Print Name:_____

Parent/Guardian Signature/Representative:_____ Date:_____

(If the authorization is signed by a personal representative of the patient, such as a parent or guardian, a document authorizing such representative's authority to act for the patient must be provided.)

Witness Signature:_____ Date:_____