

Lisa Kays, LICSW
Psychotherapy
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Washington, D.C. 20036
Phone: 202-350-1640

Authorization to Release Information Related to Mental Health Treatment

I, _____, whose Date of Birth is _____, authorize Lisa Kays, LICSW, to disclose
to and/or obtain from: _____ the following information:

Description of Information to be Disclosed

(Patient/Client should initial each item to be disclosed)

- | | |
|--|---|
| <input type="checkbox"/> Assessment | <input type="checkbox"/> Nursing/Medical Information |
| <input type="checkbox"/> Diagnosis | <input type="checkbox"/> Educational Information |
| <input type="checkbox"/> Psychosocial Evaluation | <input type="checkbox"/> Discharge/Transfer Summary |
| <input type="checkbox"/> Psychological Evaluation | <input type="checkbox"/> Continuing Care Plan |
| <input type="checkbox"/> Psychiatric Evaluation | <input type="checkbox"/> Progress in Treatment |
| <input type="checkbox"/> Treatment Plan or Summary | <input type="checkbox"/> Demographic Information |
| <input type="checkbox"/> Current Treatment Update | <input type="checkbox"/> Any and All Information |
| <input type="checkbox"/> Medication Management Information | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Presence/Participation in Treatment | |

Purpose

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services. If the purpose is other than specified above, please specify:

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Lisa Kays, LICSW at the address above. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration

Unless sooner revoked, this authorization expires 90 days following client's last visit/discharge from treatment or as otherwise indicated: _____

Conditions

I further understand that Lisa Kays, LICSW, will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences:

[Insert an explanation of consequences, if any, of not signing this authorization, which will depend on the services being provided].

Form of Disclosure

Unless you have specifically requested in writing that the disclosure be made in a certain format, I reserve the right to disclose information as permitted by this authorization in any manner that I deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Redisclosure

I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections.

Signature of Patient/Client

Date

Signature of Parent, Guardian or Personal Representative

Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.).

Check here if patient/client refuses to sign authorization

Signature of Staff Witness

Date