

Dorothy O'Keefe Diana, MSW LCSW, NJ Lic. #44SC05486500
37 Kings Road, Madison, NJ 07940

Mental Health Treatment

I, _____ [Insert Name of Patient/Client], whose Date of Birth is _____,

authorize [Insert Name of Social Work Organization] to disclose to and/or obtain from:

_____ the following information:
[Insert Name of Person or Title of Person or Organization]

Description of Information to be Disclosed

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

- | | |
|---|-----------------------------------|
| _____ Assessment | _____ Nursing/Medical Information |
| _____ Diagnosis | _____ Educational Information |
| _____ Psychosocial Evaluation | _____ Discharge/Transfer Summary |
| _____ Psychological Evaluation | _____ Continuing Care Plan |
| _____ Psychiatric Evaluation | _____ Progress in Treatment |
| _____ Treatment Plan or Summary | _____ Demographic Information |
| _____ Current Treatment Update | _____ Other _____ |
| _____ Medication Management Information | _____ Other _____ |
| _____ 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 other purpose, please specify: _____

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to [Dorothy O'Keefe-Diana, MSW, LCSW] at [37 Kings Road, Madison NJ 07940]. 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 consent expires on the following date: _____ or as otherwise indicated: _____

Conditions

I further understand that [Dorothy O'Keefe Diana, MSW, LCSW] 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 the 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, we reserve the right to disclose information as permitted by this authorization in any manner that we 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.

I will be given a copy of this authorization for my records.

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