AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

The purpose of this form is to authorize ***Justin Der, M.A., M. Div, LCPC, 14221 Metcalf Ave, Ste 130, Overland Park KS 66223*** *to share protected health information with the identified third party for the purposes of treatment, payment, and health care operations. If you refuse to authorize any such disclosure, complete the box labeled "Restriction on Disclosure." Otherwise, please complete the form as indicated.*

CLIENT:

____ ____________________

Last Name First Name MI Date of Birth

THIRD PARTY:

____

Organization/Individual Name

____

Address

____

Telephone/Fax

I authorize ***Justin Der, M.A., M. Div, LCPC*** **to (check all that apply):**

☐ release to ☐ obtain from ☐ discuss with

the third party identified above the specified protected health information listed below for purposes of treatment, payment, and health care operations.

CHECK EACH APPLICABLE ITEM:

_____ Admission Evaluation Report
_____ Diagnosis Only
_____ Treatment Plan(s)
_____ Psychiatric Consultation Report
_____ Psychological Evaluation Report
_____ Discharge Summary
_____ Progress Review(s)
_____ Alcohol and Drug Treatment Information
_____ Hospitalization Screening
_____ Progress Notes from __________ to __________
_____ Medical Reports
_____ Legal Reports
_____ Education Reports
_____ HIV/AIDS Information
_____ Other: ____

This authorization shall remain in effect until ________________ (date) at which time this authorization expires, but no later than one year from the date listed below. If this item is left blank, the authorization shall remain effective for one year from the date listed below.

I understand that enrollment, eligibility, payment, or treatment is not conditioned upon the execution of this authorization. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations. I understand that fees may be charged for preparing and sending copies of records. I understand that I may revoke this authorization at any time (except to the extent that action has been taken in reliance upon it) by providing verbal or written notice of revocation to ***Justin Der, M.A., M. Div, LCPC.***

____ __________________________

Signature of Client/Client Representative Date

____

Printed Name of Client Representative and Relationship to Client Representative Address and Phone Number

____

Signature of Witness

RESTRICTION ON DISCLOSURE: The sharing of protected health information between any third party who has or is treating the Client and ***Justin Der, M.A., M. Div, LCPC*** for the purposes of treatment, payment, or health care operations is not authorized.

____ __________________________

Signature of Client/Client Representative Date

____

Printed Name of Client Representative and Relationship to Client Representative Address and Phone Number

____

Signature of Witness

Original to be Filed in Client Record. Copy to Client or Client Representative.