Kelley Casey, LCSW
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Authorization for Release of Information

Client information:
Name_____ DOB_____

Address:_____

I, _____ authorize

_____ the disclosure of information from Kelley Casey, LCSW

_____ the release of information from:

_____

_____

_____

for the purpose of:

_____ Clinical case management services, records and plans

_____ On-going collaboration and coordination of services.

Specific information to be released:

_____ Evaluation, treatment plan, and progress

_____ Medical information relevant to the psychotherapy treatment process

_____ Other: _____

This authorization shall remain in effect until 30 days after termination of treatment unless otherwise specified:
_____

- I understand I have the right to revoke this authorization in writing, at any time by sending such written notice to my therapist's office address. However my revocation will not be effective, to the extent that the therapist has taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
- I understand that my therapist generally may not condition therapeutic services upon my signing an authorization unless the therapeutic services are provided to me for the purpose of creating health information for a third party.
- I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer protected by HIPAA Rule. The confidentiality of this information is protected by Federal Regulations and/or state statutes. Federal Regulation 42CFR, Part 2 prohibits any further disclosures of this information without the specific written consent of the person to whom it pertains A general authorization for the release of medical or other information if held by another party is not sufficient for this purpose.

_____ _____

Client/Parent Signature Date Kelley Casey, LCSW Date