Mares Cares Counseling

628 Commanche Rd., Chillicothe, OH 45601
(740) 804-6800 / (740) 721-4155 fax
www.mares-cares.com

Authorization to Release Mental Health Treatment Information

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

authorize Mares Cares Counseling LLC to disclose to and/or obtain from:

_____ [Therapist/Staff] the following information:

Description of Information to be Disclosed
(Patient/Client OR Parent or Guardian of client under 18 years of age) should initial each item to be disclosed)

_____ Consent for Treatment
_____ Mental Health Assessment
_____ Individualized Service Plan
_____ Discharge Summary
_____ Appointments Attendance
_____ Psychotherapy Notes
_____ Video (Date(s): _____)
_____ Other _____

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.

Revocation
I understand that I have a right to revoke this authorization, in writing, at any time by mailing or faxing written notification to Mares Cares Counseling LLC at the contact information provided at the top of this form.

Expiration
Unless sooner revoked, this authorization expires on the following date: _____ or as otherwise indicated:_____

Conditions
I further understand that Mares Cares Counseling LLC will not condition my treatment on whether I give authorization for the requested disclosure.

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 Printed Name Date

_____
Signature of Parent or Guardian Printed Name Date

_____
Signature of Staff Witness Printed Name Date