AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

Authorization for Use/Disclosure of Information: I voluntarily consent to an authorize my mental health professional Jan F Culpepper, LCMHC, Culpepper Counseling
to use or disclose my health information during the term of this Authorization to the recipient(s) that I have identified below.

Recipient: I, _____,authorize my health care information to be ☐ released to following participant and/ or ☐ the following participant provides health care information as stated below:

Name:_____

Address:_____

Phone & Fax (if available):
Phone: _____
Fax _____

A SEPARATE AUTHORIZATION, AS DEFINED BY HIPAA, IS REQUIRED FOR PSYCHOTHERAPY NOTES.

☐ Academic testing results	☐ Psychological testing results
☐ Behavior programs	☐ Service plans
☐ Progress reports	☐ Summary reports
☐ Intelligence testing results	☐ Vocational testing results
☐ Medical reports	☐ Entire record, except progress notes
☐ Personality profiles	☐ Psychotherapy notes
☐ Psychological reports	☐ Others, specify _____

The above information will be used for the following purposes:

☐ Planning appropriate treatment or program
☐ Continuing appropriate treatment or program
☐ Determining eligibility for benefits or program
☐ Case review ☐ Updating files
☐ Other (specify) _____

Refusal to sign/right to revoke: I understand that signing this form is voluntary and that if I don't sign, it will not affect the commencement, continuation or quality of my treatment at Culpepper Counseling. I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand that the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules.

I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization.

Questions: I may contact Culpepper Counseling for answers to my questions about the privacy of my health information at 33 E MAIN ST STE 7 FRANKLIN NC 28734 or by telephone at (757) 373-4155.

Your relationship to client: ☐ Self ☐ Parent/legal guardian ☐ Legal representative
☐ Other (describe) _____

If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

Client's Signature: _____ Date ____/ _____/ ____

Print name: _____

Parent/guardians/personal representative (if applicable)

Signature: _____ Date ____/ _____/ ____

Print name: _____

Witness:

Signature: _____ Date ____/ _____/ ____

Print name: _____