Release of Information
Authorization to Disclose Protected Health Information

I, (Client Name) _________________________ and Date of Birth ________hereby authorize Lisa Haysmer, LMSW, LLC to
____ Release/disclose my protected health information to
____ Obtain information from

____
Individual or Facility Name

____
Address City, State, Zip Code

____
Phone Number Fax Number

The purpose of this disclosure is (please initial) :
____ Notification of Provision of Treatment ____ Billing ____ Coordination of Care
____ Emergency Contact ____ Family Involvement ____ School Coordination
____ Continuity of Care ____ Other: _____________________________________

Information to be disclosed or obtained (please initial):
____ Diagnosis ____ Attendance ____ Emergency Only ____ Drug/Alcohol History
____ Intake Assessment ____ School Records ____ Treatment Summary ____ Treatment Progress
_____Discharge Summary ____ Psychiatric Evaluation ____ Medication Review ____ Treatment Plan
____ Statement of Treatment Concerns for Medical Procedure
____ Other: ____

I understand that my medical record may include alcohol and drug abuse records, or any information regarding communicable diseases which may include, but not limited to hepatitis, syphilis, gonorrhea, HIV/AIDS, or tuberculosis. I understand that such information is confidential and is protected by Federal Law, but that the potential exists for health information that is released with my authorization to be redisclosed by the recipient , and to be no longer protected by the Federal HIPAA law. I understand that I have the right to revoke this authorization at any time by giving written notice. This authorization will expire 180 days after discharge.

____ _____________________________________
Client/Guardian Signature Date

____ ____________________________
Therapist Signature Date