Release of Information

Authorization to Disclose Protected Health Information

I, (Client Name) _____ 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:

____ Notification of Provision of Treatment ____ Billing ____ Continuity of Care

____ Emergency Contact ____ Family Involvement ____ School Coordination

____ Continuity of Care ____ Other: _____

Information to be disclosed or obtained:

____ Diagnosis ____ Attendance ____ Emergency Only ____ Drug/Alcohol History

____ Intake Assessment ____ School Records ____ Treatment Summary ____ Treatment Progress

____ Discharge Summary ____ Psychiatric Evaluation ____ Medication Review ____ Treatment Plan

____ 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 re-disclosed 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