Alison Nightingale LPC
635 Lit Way Ashland, OR 97520-2414
(541) 631-8086
anightingalelpc@gmail.com
www.alisonnightingale.com

Authorization for Disclosure of Mental Health Treatment Information

I,_____, whose Date of Birth is _____, authorize _____to disclose to and/or obtain from: _____ the following information: (please initial) _____ Assessment _____ Diagnosis _____ Psychosocial Evaluation _____ Psychological Evaluation _____ Psychiatric Evaluation _____ Treatment Plan or Summary _____ Current Treatment Update _____ Medication Management Information _____ Presence/Participation in Treatment _____Nursing/Medical Information _____ Educational Information _____ Discharge/Transfer Summary _____ Continuing Care Plan _____ Progress in Treatment _____ Demographic Information _____Psychotherapy Notes* (*Cannot be combined with any other disclosure) _____Other_____ _____Other_____

Purpose This information may be used or disclosed in connection with mental health treatment, payment, or healthcare operations. If the purpose is other than as specified above, please specify: **Revocation** - I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Alison Nightingale LPC at 635 Lit Way, Ashland, OR. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization. **Expiration** - Unless sooner revoked, this authorization expires on the following date: _____ or as otherwise indicated: _____ _____**Conditions** - I further understand that Alison Nightingale LPC will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences: _____ _____

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 stricter than HIPAA and provides additional privacy protections. I will be given a copy of this authorization for my records.

_____

Signature of Client Date

_____Check here if client refuses to sign authorization _____