# THERAPEUTIC PARTNERS, PLLC

## AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

I, ____________________________________________[Name of Client], whose Date of Birth is ___________,

authorize Therapeutic Partners, PLLC located at 7406-F Chapel Hill Road, Raleigh, NC 27607 to disclose to and/or obtain protected health information From:

________________________________________________
Name

________________________________________________
Address

________________________________________________
Telephone Number

The purpose of this disclosure is for:

____ Treatment planning
____ Referral/Coordination of Care
____ Billing/Payment
____ Discharge Planning
____ Other (specify) _________________

Information to be disclosed:

____ Treatment progress summary
____ Demographic Information
____ Academic/Intelligence testing results
____ Psychological testing results
____ Progress note documentation
____ Psychiatric Evaluation
____ Other (specify)__________________________
____ Continuing Care Plan
____ Diagnosis
____ Presence/Participation in Treatment
____ Treatment/Service Plan
____ Discharge/Transfer Summary
____ Medical History and Physical

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Therapeutic Partners. 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.

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.

Re-disclosure

I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be re-disclosed 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.

My right to confidentiality has been explained to me. I understand the information to be released, the purpose of the release, and the regulations protecting my confidentiality. I understand that the provision of services is not contingent upon my agreement to sign an authorization for the disclosure of protected health information. This authorization is only for the limited purpose of obtaining from or releasing to, and discussing my case with these individuals or agencies for the specific purposes of evaluation and treatment. It shall not be considered a blanket waiver of all privileged and confidential information.

This authorization shall remain in effect for one year, ending _____/_____/_____ .

______________________________________________ ________________
Signature of client or Legal Guardian Date

______________________________________________ ________________
Signature of therapist Date