Trish Miller, LCSW
Inner Compass Counseling, LLC
1661 North Water Street, Suite 415
Milwaukee, WI 53202
414-246-1075 (o)

Standard Authorization Mental Health Treatment

I, _____, whose date of birth is _____authorize Trish Miller, LCSW to disclose to and/or obtain from:

Individual/Agency _____
Address _____
_____
Phone/Fax _____

The following specific information from confidential records:

(Client should initial each item to be disclosed)

_____ Assessment
_____ Diagnosis
_____ Psychosocial Evaluation
_____ Psychological Evaluation
_____ Psychiatric Evaluation
_____ Treatment Plan or Summary
_____ Current Treatment Update
_____ Medication Management
_____ 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

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and coordinate treatment services.

Revocation

I understand that I have a right to revoke this authorization at any time by sending written notification to Trish Miller, LCSW at Inner Compass Counseling, LLC, 1441 North Water Street, Suite 415. Milwaukee, WI 53202. 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

This release, unless revoked earlier, shall be valid for one year from the date of signing.

Conditions

I further understand that Trish Miller, LCSW 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:

_____

_____

(*Insert an explanation of the consequences, if any, of not signing this 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.

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 more strict than HIPAA and provides additional privacy protections.

I hereby release Trish Miller, LCSW and her agents from all legal responsibilities or liability consistent with this authorization.

A copy or electronic transmission of this release should be considered as valid as the original.

I will be given a copy of this authorization for my records.

_____

Signature of Client Date

_____

Signature of Parent, Guardian or Personal Representative* Date

*If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.).

_____

Signature of Staff Witness Date

_____Check here if patient/client refuses to sign authorization