HEALTH ASSOCIATES

Counseling and Psychological Services

Richard Grana, Ph.D. Martin G. Groff, Ph.D.
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This form, when completed and signed by you, authorizes the release of protected information from your clinical record to the person you designate.

I, _____ (Date of Birth) _____

Address _____

Authorize _____
(name of person or organization making disclosure)

to disclose to _____
(person or organization to which disclosure is made)

the following information: (Please check reports or information to be released)

_____ Diagnosis **_____ Reason for Termination**

_____ Medication **_____ Recommendations**

_____ Progress & Treatment **_____ # of kept / unkept appointments**

_____ Social History **_____ Psychiatric Evaluation**

_____ Classroom / Medical / Psychological Records

_____ Other **_____Alcohol/Drug Related Information**

The purpose for disclosure is:

_____ To comply with court order **_____ Treatment of Client**

_____ To comply with doctor referral **_____ Collaboration with School**

_____ Other _____

This consent will expire at the end of 60 days or as specified here: _____
(Identify date, event or condition which terminates consent)

I understand that my records are protected under the Federal Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I have the right to revoke this authorization, in writing, at any time by sending such written such written notification to the Health Associates office address. However, my revocation will not be effective to the extent that Health Associates has taken action on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that information used or disclosed after the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule, and Health Associates is not responsible for any subsequent disclosure. I understand that my therapist generally may not condition treatment services upon my signing an authorization unless the therapy services are provided to me for the purpose of creating health information for a third party.

_____ _____
Signature of Client **Date Signed**

_____ _____
Signature of parent, guardian **Signature of Witness**

NOTE: The receiving agency understands that it CANNOT RELEASE any of the confidential information received without the client's written consent.