

Marcia E. Brubeck, LLC

114 Somerset Street, West Hartford, CT 06110 • Phone (860) 231-1997 • Fax (860) 231-1960

Authorization for Information Regarding Mental Health Treatment

I, _____, the Client, Date of Birth _____, authorize Marcia E. Brubeck, LLC, to disclose to and/or obtain from:

_____ the following information:
[Insert Name of Person or Title of Person or Organization]

- | | |
|---|---|
| _____ Assessment | _____ Educational Information |
| _____ Diagnosis | _____ Discharge/Transfer Summary |
| _____ Psychosocial Evaluation | _____ Continuing Care Plan |
| _____ Psychological Evaluation | _____ Progress in Treatment |
| _____ Psychiatric Evaluation | _____ Demographic Information |
| _____ Treatment Plan or Summary | _____ Psychotherapy Notes* |
| _____ Current Treatment Update | (*Cannot be combined with any other disclosure) |
| _____ Medication Management Information | _____ Other _____ |
| _____ Presence/Participation in Treatment | _____ Other _____ |
| _____ Nursing/Medical Information | |

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

Marcia E. Brubeck, LLC, hereby declares that the purpose does not and will not include marketing, sale of information, or research.

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Marcia E. Brubeck, LLC, 114 Somerset Street, West Hartford, CT 06110. 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.

Unless sooner revoked, this authorization expires on the following date: _____ or one year from the date of signing.

I further understand that Marcia E. Brubeck, LLC 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:

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.

I understand that the protected health information disclosed pursuant to this authorization could possibly be redisclosed by the recipient and that the protected health information will then 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 hereby affirm that I have received a copy of this authorization for my records.

_____ Signature of Patient/Client	_____ Date
_____ Signature of Parent, Guardian, or Personal Representative (indicate type).	_____ Date
_____ Signature of Staff Witness	_____ Date