Release of Information

As required by the Privacy Regulations, Deborah J. Beaver may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization.

Client Name: _____ Date of Birth: _____

Address: _____

I hereby authorize Deborah J. Beaver and Mark S. Kosins, M.D. and Associates, disclose and/or receive Client Health Information with the following person / organization. I understand that the information disclosed below may be re-disclosed to additional parties and no longer protected for reasons beyond our control.

Name: _____

Organization: _____

Address: _____

Telephone: _____

Client Health Information authorized to be disclosed may include any or all of the following:

☐ Drug/Alcohol Treatment Records ☐ Therapy/Counseling Records ☐ Psychological Evaluations

☐ Medical Records ☐ Psychiatric Evaluations ☐ _____

☐ Discharge Summaries ☐ Telephone communication

For the specific purpose of (describe in detail): _____

_____

_____

I authorize this release to be effective on _____/_____/_____ through _____/_____/_____

I understand I have the right to:

1. Revoke this authorization by sending written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization.
2. Knowledge of any compensation involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
3. Inspect a copy of Client Health Information being used or disclosed under federal law.
4. Refuse to sign this authorization.
5. Receive a copy of this authorization.
6. Restrict what is disclosed with this authorization.

I also understand that if I do not sign this document, it will not affect the condition of my treatment, payment, enrollment in a health plan, or eligibility for benefits.

_____ _____

Signature of Client or Client's Authorized Representative Date

_____ _____

Authorized Signature of Facility Representative Date