Nedra Koenig, M.A.
Licensed Marriage and Family Therapist

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

1. I am completing this form to allow the use and sharing of protected health information about:
   *Printed Name*_____ *DOB* _____

2. I authorize this person or organization _____

   Mailing Address _____

   Telephone _____

3. To use or disclose the following information:
   - □ Inpatient or outpatient treatment records for physical and/or psychological, psychiatric, or emotional illness.
   - □ Admission and discharge summaries.
   - □ Psychological or psychiatric evaluation(s), reports, assessments, treatment notes, testing records, or other documents with diagnoses, prognoses, recommendations, or testing records, and behavioral observations or checklists completed by any staff member or the patient, or similar documents.
   - □ Treatment, recovery, rehabilitation, aftercare plans and other similar plans.
   - □ Social, family, educational, and vocational histories.
   - □ Social work assessments, occupational therapy and vocational reports and evaluations.
   - □ Progress, nursing, case or similar notes
   - □ Evaluations and reports of consultants.
   - □ Information about how the patient's condition(s) affects or has affected his or her ability to work, and to complete tasks or activities of daily living.
   - □ Academic and educational records, including achievement and other tests' results, reports of teachers' observations, and all other school or special education documents.
   - □ Drug and alcohol information contained in reports.
   - □ Complete copy of the medical record and the folder in which it was kept.
   - □ Other: _____

   Dates of care included: From: _____ to _____

4. To the following person or organization: _____

Mailing Address _____

Telephone _____

5. The information will be used/disclosed for the following purposes: _____
   _____.

6. I understand and agree that this Authorization will be valid and in effect until _____.

340 N. Rangeline Road, Carmel, IN 46032
Phone: (317) 564 - 8610
Fax: (317) 815 - 9223

I understand that after that date or event, no more of this information can be used or released to the person or organization unless I sign a new Authorization like this one.

7. I understand that I can revoke or cancel this Authorization at any time by sending a letter to Nedra Koenig, M.A. who is to supply this information. If I do this, it will prevent any disclosures after the date it is received but can not change the fact that some information may have been sent or shared before that date.

8. I understand that I do not have to sign this Authorization and that my refusal to sign will not affect my abilities to obtain treatment from the professional or facility listed at #2, nor will it affect my eligibility for benefits.

9. I understand that I may inspect and have a copy of the health information described in this Authorization. There may be a cost for this copy or other services. □This does not apply.

10. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above my be redisclosed and no longer protected by those regulations.

11. I understand that the professional or facility listed in #2, above, will receive compensation for the use or disclosure of my health information. The arrangement has been explained to me and I understand and accept it.
    □This does not apply.

12. I affirm that everything in this form that was not clear to me has been explained and I believe I now understand all of it.

_____ _____
Signature of client or his/her personal representative *Date*

_____ _____
Printed name of client or personal representative *Relationship to client*

□ I acknowledge that I received a copy of this completed form

I, a mental health professional, have discussed the issues above with the client and/or her personal representative. My observations of his/her behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ Nedra Koenig, M.A., LMFT _____
Signature of professional *Printed name* *Date*

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