**Waiver of Privacy Rights & Authorization for Release of Information**

I hereby authorize Infinite Abilities Counseling, LLC to release and/or

discuss the information listed below with the following person(s):

|  |  |
| --- | --- |
| ▢ Clinician Progress Notes | ▢ Individual Treatment Plan |
| ▢ Client’s Presence in Treatment | ▢ MH/SA Assessment |
| ▢ Current Medications | ▢ Health Related Information |
| ▢ Discharge Summary | ▢ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

As a person signing this authorization, I acknowledge that I am giving my permission to the above named person to disclose and use protected health information. I further acknowledge that:

* I may refuse to sign this authorization.
* Aryn Gentry cannot condition the provision of treatment to me on my signing this authorization.
* The original or a copy of this authorization will be included my medical record.
* I have the right to revoke this authorization in writing at any time, but is not retroactive to any information already released in accordance to the authorization.
* My rights are defined under Federal laws (substance abuse is 42 CFR and HIPAA Privacy Standards45 CFR Parts 160 and 164) as well as under the Commonwealth of Virginia’s Administrative Code, Title 12, sections 35-155-80 and 35-115-90 (Human Rights).
* There is potential for any information disclosed pursuant to this authorization to be subject to re-disclosure by the recipient and therefore, no longer protected by the provisions of the HIPAA Privacy Rule. If this information is being disclosed from records protected by the Federal Substance Abuse Confidentiality Rules (42 CFR, part 2), the Federal rules prohibit the recipient from making any further disclosures of this information unless further disclosure is expressly permitted by your written authorization or as otherwise permitted by 42 CFR, part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse person.

If not previously revoked, this authorization will expire on:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

This information may be disclosed effective ▢ Immediately ▢ Specify Date: \_\_ \_\_ / \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_

This authorization ▢ does ▢ does not extend to information placed in my record after the date I signed this form.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Print Name Sign Name Date Signed

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Relationship Signature of Minor Date Signed

The mechanism used to disclose the information is as noted: ▢ written ▢ verbal