LRS CENTER for EMOTIONAL WELLBEING, PLLC
1010 Lamond Ave., P.O. Box 52715, Durham, NC 27717-2715

Authorization to Release Protected Health Information (PHI)

I/We, _____ and _____, whose Date of Birth is/are _____, and _____ authorize Liliana R. Sznaidman, MS, LPC-S

to disclose to and/or obtain from:_____
[Insert Name of Person or Title of Person or Organization & Phone Number]
the following information regarding:
____ Self ____Other: Name_____Date of Birth_____
My legal relationship:_____

Description of Information to be Disclosed (Patient/Client should initial each item to be disclosed)

_____Treatment Summary (assessment/ diagnosis/progress/recommendations)
_____ Psychosocial Evaluation/Information
_____ Diagnosis
_____ Treatment Plan
_____ Presence/Participation in Treatment
_____ Update/Progress in Treatment
_____Other_____
_____
_____

_____ Psychological Evaluation
_____ Psychiatric Evaluation
_____ Medication Management Information
_____Nursing/Medical Information
_____ Toxicological Reports/Drug Screens
_____ Intake/Assessment
_____ Discharge Summary
_____ Educational Information
_____ Behavioral/Social Observations
_____Other_____

Purpose

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.
If other purpose, please specify: _____

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to my therapist at the above address. 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.

Expiration

Unless sooner revoked, this consent expires one (1) year from the date signed, while my treatment with the provider is ongoing. However, this consent will automatically expire three (3) months after the last date of service.

Conditions

I further understand that Liliana R. Sznaidman, MS, LPC-S, will not condition my treatment on whether I give authorization for the requested disclosure.

Form of Disclosure

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.

Redisclosure

Federal law prohibits the person or organization to whom disclosure is made from making any further disclosure of substance abuse treatment information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. Other types of information may be re-disclosed by the recipient of the information subject to the same rules governing release of other PHI.

I will be offered a copy of this authorization for my records.

_____
Signature of Patient/Client or Legal Representative Date

_____
Signature of Patient/Client or Legal Representative Date

____Check here if client refuses to sign authorization.

____Check here if legal representative refuses to sign authorization.

If you are signing as a personal representative of an individual, please use the "My legal relationship" line, above, to describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.).

_____
Signature of Therapist Witness Date