Anna Zurek, LMFT

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AUTHORIZATION TO USE / DISCLOSE HEALTH INFORMATION

I authorize **Anna Zurek, LMFT/Thrive Within Counseling,** to use / disclose and furnish/receive of specific health and clinical information described in the areas I have identified below regarding:

_____ _____

Name of patient Date of birth

Please check box(es):

□ Unlimited access
□ Assessments, Consultations & Evaluations
□ Participation in Treatment
□ Chart notes
□ Discharge Summary/Transfer Summary
□ Demographic and insurance information
□ Verbal
□ Diagnosis
□ Progress in Treatment
□ Medication management information
□ Doctor's reports, hospital reports
□ OTHER (please specify): _____

To/From: _____ _____

Name of recipient Phone Number/Fax Number

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.

Revocation: You have the right to revoke this Authorization at any time, provided you do so in writing. IF you revoke your Authorization, I will no longer use or disclose information about you for the reasons covered by your written Authorization, but I cannot take back any uses or disclosure already made with your permission. To revoke this Authorization, please send a written statement to Anna Zurek, LMFT/Thrive Within Counseling, at 145 S. Holly Street, Suite B, Medford, OR 97501. The notice should include the full name and relationship of the person you are revoking privileges from, along with your full name, date of birth, current date and signature. The information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and is no longer protected under federal law.

Expiration: Unless sooner revoked, this authorization expires on the following date:

_____

Form of disclosure: Unless you have specifically requested in writing that the disclosure be made in a certain format, I reserve the right to disclose information as permitted by this authorization in any manner that I deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Redisclosure: I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applied that is more strict than HIPAA and provides additional privacy protections.

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

_____ _____

Signature of Client Date

_____ _____

Signature of Parent or Guardian Date