Honeycutt Counseling, LLC
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Authorization to Disclose Health Information

I,____Date of Birth__________________________
(Name of person whose information is being requested)

Authorize:____
(Name and address of person making the disclosure)

To Disclose to:____
(Name and address of person receiving information)

The following information (circle Y for yes and N for No for each type of information):

Information Type	Information Type	Information Type
Y Attendance N	Y Diagnosis/presenting problem N	Y Entire Record N
Y Treatment Recommendations N	Y Progress report on Treatment N	Y Discharge Summary/Plan N
Y Treatment Plan N	Y Other (Specify) N	Y Other (Specify) N

The purpose of this disclosure is: to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services. and / or:

____

Dates and more specific information:

____

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Means of disclosure (check all that apply):____Written ___Oral ____Electronic ____Other (specify):__________

I understand that federal regulations prohibit the redisclosure of drug & alcohol treatment information without my written consent or as allowed by the regulations. I understand that my health information can only be disclosed with my authorization or as mandated by an express provision of law.
I understand that my treatment is not conditioned upon authorization of this disclosure.
I understand that I may revoke this authorization at any time except to the extent that the person making the disclosure has already acted in reliance on it. In general, *revocation should be submitted in writing and sent to the address listed above.*

Date or event upon which this authorization will expire:____
I understand if I do not note a date or event, then this authorization will expire one year from the date it was signed below.

Client Signature:____Date____________

Clinician's Signature:_______________________________________Date____________

I revoke this authorization on this date______________________Time___________