Authorization to Disclose Information

Client Name: _____Date of Birth: _____
I authorize Theresa M Cukierski, LLC to ☐ Obtain Information from, ☐ Disclose Information to, or ☐ Exchange Information with the Authorized Organization or Individual noted below.
_____Rachel Primeau, MSW, LISW_____
Name of Authorized Organization or Individual from Whom Disclosure is to be made
Phone Number: _____419-260-9467_____
Street Address: _____606 West Sophia Street_____
City/State/Zip Code: _____Maumee, OH 43537_____

The Information to be Disclosed (check each specific item to be disclosed)

- ☐ Biopsychosocial/Diagnostic Assessment
- ☐ Recommendations/Prognoses
- ☐ Legal History/Probation/Parole Info
- ☐ Discharge Summary/Continuing Care Plan
- ☐ Other: _____
- ☐ Treatment Plan
- ☐ Progress Notes
- ☐ Treatment Dates
- ☐ Billing/Payment Information

Amount of Information to be Disclosed: ☐ information covering all previous and current admission ☐information covering current admission only ☐information covering the previous 3 months ☐specific dates: _____
This release will expire: ☐ 3 months ☐ 6 months ☐ 12 months ☐ Specific date: __03/19/2018____

The information released is for professional purposes only. Only the minimum amount of information needed to achieve the purpose may be disclosed. It may not be provided in whole or part to any other agency, organization, or person other than that which is stated above. I have read and agree that all the information was properly completed prior to my signing the form, understand that this form is not required as a condition for treatment, and have the right to access the information to be disclosed. I have the right to shorten or lengthen the authorization at any time. This authorization is subject to revocation at any time except to the extent that Theresa M Cukierski, LLC has already acted in reliance on it. The revocation must be in writing. I understand that Theresa M Cukierski, LLC cannot guarantee that the recipient will not disclose my health information to a third party and the recipient may not be subject to referral laws governing privacy of health information. However, if the disclosure consists of treatment information about alcohol or drug abuse treatment, the recipient is prohibited from re-disclosure under federal law (42 CFP, Part 2). See notice below.

_____ ____/____/____ _____ ___/____/____
(Client Signature) (Date) (Parent/Guardian/Authorized Personal Representative Signature) (Date)

_____ ____/____/____ _____ ___/____/____
(Witness) (Date) (Parent/Guardian/Authorized Personal Representative Printed) (Date)

Prohibition Against Re-Disclosure: This information has been disclosed to you from record protected by Federal Confidentiality rules. The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization from the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse client. (these conditions apply to every page disclosed and a copy of this authorization will accompany each disclosure).

Revoke Authorization:
Client/Guardian has revoked this authorization as of: _____
Signature: _____
Witness: _____