AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

<u>Authorization for Use/Disclosure of Information</u>: I voluntarily consent to an authorize my mental health <u>professional Jan F Culpepper, LCMHC of Culpepper Counseling PLLC</u>
to use or disclose my health information during the term of this Authorization to the recipient(s) that I have identified below.

<u>Recipient</u>: I, ___________________________,authorize my health care information to be ☐ released to following participant and/ or ☐ the following participant provides health care information as stated below:

Name:____

Address:____

Phone & Fax (if available):
Phone: ________________________
Fax ___________________________

A SEPARATE AUTHORIZATION, AS DEFINED BY HIPAA, IS REQUIRED FOR PSYCHOTHERAPY NOTES.

______ Academic testing results
______ Behavior programs
______ Progress reports
______ Intelligence testing results
______ Medical reports
______ Personality profiles
______ Psychological reports
______ Psychological testing results
______ Service plans
______ Summary reports
______ Vocational testing results
______ Entire record, except progress notes
______ Psychotherapy notes
______ Others, specify ________________

The above information will be used for the following purposes:

______ Planning appropriate treatment or program
______ Continuing appropriate treatment or program
______ Determining eligibility for benefits or program
______ Case review ______ Updating files
______ Other (specify) ____

<u>Refusal to sign/right to revoke</u>: I understand that signing this form is voluntary and that if I don't sign, it will not affect the commencement, continuation or quality of my treatment at Culpepper Counseling. I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand that the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules.

I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization.

Questions: I may contact Culpepper Counseling for answers to my questions about the privacy of my health information at 712 Hwy 64, Manteo, NC, or by telephone at (757) 373-4155.

Your relationship to client: ____Self ____Parent/legal guardian____Legal representative
____Other (describe) ________________________________

If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

Client's Signature: ________________________________ Date ____/ _____/ ____

Print name: ______________________________________

Parent/guardians/personal representative (if applicable)

Signature: __________________________________ Date ____/ _____/ ____

Print name: ______________________________________

Witness:

Signature: __________________________________ Date ____/ _____/ ____

Print name: ______________________________________