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BALDWIN COUNSELING, P.L.L.C.
Standard Authorization to:

DISCLOSE/RELEASE

INFORMATION FROM BALDWIN COUNSELING TO ANOTHER AGENCY OR PERSON

I, Child's Name_____[**Insert Name of Parent/Client],** whose Date of Birth is _____DOB,

authorizes Baldwin Counseling and/or Suzanne Baldwin to disclose/release information about myself _____*or*

my child Child's Name_____ to:
[Insert Name of Child and Date of Birth of Child]

Person or Agency_____
[**Insert Name of Person or Agency and Contact Information on the line above**]

Description of Information to be Disclosed/ Released

(Patient/Client should initial each item to be disclosed)

_____ Assessment
_____ Diagnosis
_____ Psychological Evaluation
_____ Treatment Plan or Summary
_____ Current Treatment Update
_____ Presence/Participation in Treatment
_____ Discharge/Transfer Summary
_____ Continuing Care Plan
_____ Progress in Treatment
_____ Demographic Information
_____Psychotherapy Notes
_____Other_____
_____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.

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Suzanne Baldwin at 1492 South Independence Blvd, Suite 104, Virginia Beach, VA 23464. 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 authorization expires one year from the date of signature or other defined date.

_____

Conditions

I further understand that Baldwin Counseling will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences: (1) the inability to collaborate fully to maximize clinical services and (2) facilitate transfer of services.

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

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 applies that is more strict than HIPAA and provides additional privacy protections.

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

Date

_____

Signature of Patient/Client Date

Date

_____

Signature of Parent, Guardian or Personal Representative and Relationship Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.).

☐ Check here if patient/client refuses to sign authorization