BALDWIN COUNSELING
Standard Authorization
TO RECEIVE
Mental Health Treatment

I,_____ , (Client or parent of client) whose Date of Birth is _____

authorize Baldwin Counseling and/or Dr. Suzanne Baldwin to disclose about myself_____ or my

child_____ to:
[Name] [DOB]

_____
[**Insert Name of Person or Title of Person or Organization**] the following information:

Description of Information to be Disclosed: **(Initial each item to be disclosed)**

____Assessment	____Educational Information
____Diagnosis	____Discharge/Transfer Summary
____Psychosocial Evaluation	____Continuing Care Plan
____Psychological Evaluation	____Progress in Treatment
____Psychiatric Evaluation	____Demographic Information
____Treatment Plan or Summary	____Psychotherapy Notes*
____Current Treatment Update	(*Cannot be combined with any other disclosure)
____Medication Management Information	CAL/DHS/Legal
____Presence/Participation in Treatment	____Representative
____Nursing/Medical Information	____Other_____

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.

Please note: Information cannot be released to any other party unless this consent is signed. A client's spouse or significant other will not be able to have information about appointments or schedule or cancel an appointment unless this release is signed. *Only one person may be listed on each form.* Complete a new form for each person you are authorizing release of information.

Revocation
I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Baldwin Counseling at 2832 South Lynnhaven Road, Ste 102, Virginia Beach, VA 23452. 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 on the following date:
or as otherwise
indicated: _____. If no date is chosen, this authorization will expire one year from the date it was signed.

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) possible inability to provide full treatment services; (2) inability to collaborate with other health care providers and/or legal entities, (3) inability to inform spouse or significant others of appointments and other clinical information.

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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.

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

_____

Signature of Patient/Client Date

_____

Signature of Parent, Guardian or Personal Representative 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.).

_____

Description of Authority

☐ Check here if patient/client refuses to sign authorization

_____

Signature of Witness Date