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Counseling Services of Arizona
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Authorization for Disclosure of Psychotherapy Notes

Name of Client: ____ Date of Birth: ______________________

This will acknowledge that I have given my permission for **Heidi Quinlan, LPC, LISAC** to _____ receive and/or _____ release **psychotherapy notes or billing information** which may include protected health information under HIPAA.

Purpose of disclosure (please check all that apply):

_____ Court Ordered Evaluation/Therapy ______ Therapy Coordination ______ Therapeutic Intervention

_____ Financial Information ONLY ______ Family Court Services Coordination

_____ To another health care provider for the purpose of continuity of care (e.g., PCP, Mental Health, etc.)

_____ Phone consult _____ Other:____

Complete the contact information below for who the information should be received from/released to:

____
Name of Person/Agency/Institution

____
Address/City/State/Zip Code

____
Email Address

_________________________________ ____
Phone Number Fax Number

This authorization shall remain in effect for 12 months or until the date indicated here: _______________________

You have the right to revoke this authorization, in writing, at any time by sending such written notification to the releasing person/agency address. However, your revocation will not be effective to the extent that the person/agency has taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that I am entitled to a copy of this authorization. I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of my information and no longer protected by the HIPAA Privacy Rule.

For the purpose hereof "Records" and/or "Information" shall include confidential HIV-related information (as defined in A.R.S. Section 36-661), confidential communicable disease-related information (as defined in A.R.S. Section 36-661), and confidential alcohol or drug abuse-related information (as defined in 42 CFR Section 2.1 ET SEQ) the restrictions of which have been specifically considered and expressly waived.

____ ________________________
Signature of Client Date

____ ________________________
Signature of Parent/Legal Guardian or Personal Representative (Indicate which) Date

____
Printed Name