Joy G. Bressler, Ph.D., LCSW, LLC
312 Granite Avenue
Richmond, Virginia 23226
804-651-7667

Authorization to Release/Obtain/Exchange Mental Health Treatment Information

I, ______________________________[Insert Name of Patient/Client], whose Date of Birth is ______, authorize **Joy G. Bressler, Ph.D., LCSW, LLC** to disclose to and/or obtain from or exchange with:

____ the following information:
[Insert Name/Address of Person or Title of Person or Organization]

Description of Information to be Disclosed

(**Please initial each item to be disclosed**)

_____ Assessment/Intake
_____ Diagnosis
_____ Psychosocial Evaluation
_____ Psychological Evaluation
_____ Psychiatric Evaluation
_____ Treatment Plan or Summary
_____ Current Treatment Update
_____ Medication Management Information
_____ Presence/Participation in Treatment
______Nursing/Medical Information
_____ Educational Information
_____ 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 **Joy G. Bressler, Ph.D., LCSW, LLC** at **312 Granite Avenue Richmond Virginia 23226**. 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:____

Conditions

I further understand that **Joy G. Bressler, Ph.D., LCSW, LLC** 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: ____
____
[Insert an explanation of the consequences, if any, of not signing this authorization, which will depend on the services being provided].

Form of Disclosure

NATIONAL ASSOCIATION OF SOCIAL WORKERS
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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.).

_____Check here if patient/client refuses to sign authorization

____

Signature of Staff Witness Date

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