STILLWATERS COUNSELING
4500 N 32nd St, #106
Phoenix, AZ 85018

AUTHORIZATION TO RELEASE/EXCHANGE INFORMATION

I, (name of patient) _____, with a date of birth of _____ (hereinafter "Patient") hereby authorize **Michael Rehm, LPC** (hereinafter "Provider") to disclose/exchange mental health treatment information and records obtained in the course of psychotherapy treatment of Patient including, but not limited to HIPAA Protected Health Information (PHI), with/to:

_____
_____
_____
_____

I understand that the information to be released includes records in any form, and oral conversations with the Provider. I understand that I have a right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing. I understand that I have the right to refuse to sign this authorization. I understand that I have the right to revoke this authorization at any time unless Provider has taken action in reliance upon it. And, I also understand that such revocation must be in writing and received by Provider at the address indicated above, to be effective.

This disclosure of information and records authorized by Patient is required for the following purpose:

___ Coordination of treatment with another mental health professional involved in your care.
___ Coordination of treatment with another type of health professional involved in your care.
___ To obtain insurance or other third party benefits under a managed care agreement.
___ Coordination with another type of professional (e.g., attorney).
___ To obtain benefits of programs that are not health insurance related (e.g., SSI, SSD, private disability, etc.).
___ Other _____

Such disclosure of written or oral conversations shall be limited to the following specific types of information:

___ Assessment, diagnosis, treatment plan, compliance, functionality, test results, and response to treatment.
___ Information pertaining to substance abuse or substance dependency.
___ Sensitive relationship issues, family dynamics, sexual issues, and other highly personal information. ***This information is contained in Psychotherapy Notes as defined by HIPAA. Authorization to release Psychotherapy Notes can not be combined with a release for other PHI on the same form.***
___ Other _____

The specific uses of Protected Health Information (PHI) to be discussed or released are as follows

___ Coordination of response to psychotropic medications prescribed by a psychiatrist or other physician.
___ Coordination of other medical treatment with mental health, marital, or family treatment.
___ Coordination of marital or family treatment with individual treatment.
___ Case management and/or utilization review under a managed care agreement.
___ Review of treatment and/or functionality to obtain benefits of non-health-insurance related programs.
___ Other _____

Patient understands that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule, although applicable Arizona law may protect such information.

This authorization shall remain valid for 24 months from the date signed or until revoked.

Patient's signature: _____ Date: _____

Witness (if necessary): _____ Date: _____