Blue Sky Counseling Associates, LLC

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AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

I, _____, authorize Blue Sky Counseling
(Name of Patient)

Associates, LLC, to disclose and obtain the information described below to/from:

Name of Organization:_____

Address:_____

Attention:_____ Phone:_____ Fax:_____

☐ Records, Reports, and Information Regarding Psychological Evaluations, Assessments, Treatment Plans, Summaries Discharge, Progress, Appointments, Behavior and Compliance

☐ Educational Records, Reports, and Information to Include IEPs, Grades, Attendance, Behavior, Evaluations, and Assessments

☐ Records, Reports, and Information Regarding Probation/Parole Conditions, Criminal and Delinquent History, Drug/Alcohol Use, and Compliance

☐ Behaviors or a mental state that presents a substantially and immediate high risk to the life of a client or those around them

☐ Environmental stressors and parenting issues impacting treatment progress

☐ _____

_____

The purpose of the disclosures authorized herein is to:

☐ Coordinate, Manage, and Provide Medical/Mental Health/Educational/Criminal Justice Services.

☐ _____

_____

I understand that my records are currently protected under the Federal privacy regulations within the Health Insurance Portability and Accountability Act (HIPAA), 45 C.F.R. Parts 160 & 164. I further understand that the information specified above will be disclosed pursuant to this authorization, and that the recipient of the information may re-disclose the information and it may no longer be protected by the HIPAA privacy law.

I understand that my records, with respect to alcohol and drug abuse are protected under Part 2 of Title 42 of the Code of Federal Regulations and cannot be disclosed without my written consent. I understand that if information to be released includes information regarding drug abuse/dependence and/or alcohol abuse/dependence, it may not be re-disclosed without my further written consent unless otherwise provided for in the regulations.

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this authorization expires automatically as follows: _____
(Specification of the Date, Event, or Condition upon Which This Consent Expires)

Should I decide to revoke this authorization prior to its expiration, I understand that I must do so in writing and deliver it to a legal representative of Blue Sky Counseling Associates, LLC. Although HIPPA requires that consents are revocable, 42 C.F.R. § 2.35 provides that if I am mandated into treatment through the criminal justice system or I am under legal/court supervision/probation, this authorization will remain in effect and cannot be revoked by me until there has been a formal and effective termination or revocation of my release from confinement, probation, or parole, or other proceeding under which I was mandated into treatment.

I understand that the entity seeking this authorization is permitted under Part 2 of Title 42 of the Code of Federal Regulations and HIPAA regulations to set as a condition of providing treatment, payment, enrollment in a care health plan and/or eligibility for benefits, and the signing of this authorization. By refusing to sign this authorization, I may not be accepted as a client or may be referred to another mental health provider.

I understand that I am entitled to receive a copy of this authorization after it is signed.

Dated: _____

_____
Signature of Client

_____
Signature of Parent, Guardian or Authorized Representative