CREEKSIDE COUNSELING, LLC

AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

NAME OF INDIVIDUAL:

Last	**First**	**Middle Initial**	**Date of Birth**

In order to enhance care and treatment, coordinate services, and/or meet billing, educational, or legal requirements, I authorize Creekside Counseling, LLC at P.O. Box 93, Mankato, Kansas 66956 to release and/or obtain the following checked information from:

Named Entity:

☐ **RELEASE** or ☐ **OBTAIN**

Description of Information to be Disclosed

Mental Health Information (Other than therapy notes)	Consultation Reports
Admission Evaluation/Assessment	Diagnostic Reports
Treatment Plans	Educational Reports
Discharge Summary	Legal Reports
Billing Information	Medical Reports
Hospitalization Screens	Progress Reports
Court Reports	Psychology Reports
Other	Other

I understand that:

- This authorization will expire ☐ One year from date of signature or ☐ On the following date/event:
- I understand I have a right to revoke this authorization, in writing, at any time by sending written notification to Creekside Counseling, LLC. I understand prior actions taken in reliance on this authorization by Creekside Counseling, LLC or the other named entity that had permission to access the individual's health information will not be affected.
- I understand there is the potential 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 stricter than HIPAA and provides additional privacy protections.
- I understand unless I have specifically requested in writing that the disclosure be made in a certain format, Creekside Counseling, LLC reserves the right to disclose information as permitted by this authorization in any manner that is deemed to be appropriate and consistent with applicable law, including, but not limited to, verbal, email, fax, or written communication.
- I further understand Creekside Counseling, LLC will not condition my treatment on whether I give authorization for the requested disclosure.
- A photocopy of this document is as valid as the original.
- By signing this authorization, I indicate I have read it and agree to the uses and disclosures of the information as described.

SIGNATURE:

X Signature of Individual or Individual's Legal Representative	**Date**	**Relationship**

X Signature of Witness	**Date**