MANDALA
COUNSELING SERVICES

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Authorization for Release of Health Information

Client's Name: _____ Date of Birth:_____

Medical Record:_____ Date of Authorization:_____

I give permission to Traci Withrow, LCSW dba Mandala Counseling Services to **obtain / release** information **to / from** the following as it pertains to my/my child's treatment. The specific nature of the information obtained/released will be for the purpose of treatment planning and continuity of my/my child's mental health care. It may include written, electronic and/or verbal information about my/my child's treatment goals, progress, treatment plan adherence, dates of service, social/developmental/family history, admission/discharge summaries, evaluations/assessments from other providers, medical diagnoses including medication information. I understand that the records released may include information about HIV/AIDS and/or treatment for or history of drug or alcohol abuse. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Person/Agency: _____

Contact Info: _____

Restrictions to disclosure: _____

I have the right to revoke or cancel this authorization at any time by submitting a written request to my therapist except to the extent information has already been shared based on this authorization. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected health information. Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA.

A full explanation of your rights under the Health Information Portability and Accountability Act is available at your request.

This authorization shall remain in effect until: _____

Authorizing Person's Name: _____

Authorizing Person's Signature: _____ Date: _____

Clinician's Signature: _____Date: _____