Humboldt NeuroHealth Therapeutic Services

Authorization For Release of Information

Client's Name: _____ Date of Birth:_____

I, _____ hereby authorize Humboldt Neurohealth to exchange information

(Client or Legal Guardian of minor)

with **Eureka City Schools**.

The type of information to be disclosed:

Evaluations _____ Medical/Hospital Records_____ Diagnosis _____ Psychological/Medical Test_____ Results_____ Treatment Plan_____ Mental Health Record Summary_____ Course of Treatment_____ Psychotherapy Notes _____ Other ___

☐ By checking this box I understand that my student may miss core classes. ECS and HNH will try their best to schedule appointments during elective classes.

The purpose of such disclosure:
Ongoing Treatment_____ Medical Care_____ Consultation_____ Evaluation_____ Transfer_____ Legal issues_____ Coordination of Care_____ Health Benefit Utilization_____ Other _____

Exceptions:_____

The designated information about me ( ) may ( ) may not be transmitted by fax, electronic mail or other electronic file transfer mechanisms. The above parties ( ) may ( ) may not discuss by telephone the content of the information released.

This consent is in effect until_____. I understand that I may revoke this authorization, in writing, at any time unless action based on it has already taken place.

I hereby release all parties stated herewith from any liability resulting from the release of this information. I agree that a photocopy of this release shall be as valid as the original.

I understand that my communications in therapy are protected under federal and state confidentiality regulations and cannot be disclosed without my written authorization. The information provided by a client during therapy sessions is legally confidential in the case of licensed clinical social workers, except as provided in section 12.43.218 CRS and except for certain legal exceptions. In general, these exceptions pertain to matters of danger to self or others, and to assault or neglect of children.

I further understand that the potential exists for re-disclosure of my private mental health information, and that it may no longer be protected under the HIPAA privacy regulations.

This is to certify that I have given consent freely and voluntarily, and that the benefits and disadvantages of releasing the information, if known, have been explained to me.

_____ _____

Signature of Client or Personal Representative **Date**