Dan Hooley MA LCPC || 9700 W State Street, Star, ID 83669

AUTHORIZATION TO USE & DISCLOSE PROTECTED HEALTH INFORMATION

Client_____ D.O.B____/____/____

With my signature below, I authorize Dan Hooley MA LCPC of Dan Hooley Therapy to _____**OBTAIN** information from and/or _____**DISCLOSE** information to the following:

Person_____ Organization_____

Address_____

Phone_____ Fax_____

Relationship to Client_____

Information obtained/disclosed/discussed includes the following:

_____Assessment Evaluation _____Treatment Plan _____Notes _____Treatment Status

_____Coordination of Care Information _____Other

Other Information

I understand that I am not required to sign this authorization. If I refuse to sign this, it will not prevent me from getting mental health or drug/alcohol treatment at Dan Hooley Therapy. The only exception is if the services I am seeking are only for providing health information to someone else and this authorization is needed to make the disclosure.

I may revoke this authorization in writing any time. If I revoke this authorization, the information described may no longer be used or disclosed for the reason described here. If Dan Hooley Therapy has already used or disclosed information, that cannot be undone. To revoke this authorization, I can request the form from Dan Hooley Therapy.

I understand that the information used or disclosed as a result of this authorization may be subject to re-disclosure and no longer protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS, mental health information, genetic testing information, and drug/alcohol diagnosis, treatment, or referral information.

Unless revoked, this authorization expires 90 days after the completion of treatment or _____.

My signature indicates that I have read and understand this document.

Client Signature_____ Date_____

Parent/Guardian/Representative Signature_____ Date_____