620 North 48th Street, Suite 202
Lincoln, NE 68504
Phone: 402.489.6196
Fax: 402.904.4896

MONARCH COUNSELING

Authorization For Disclosure Of Mental Health Treatment Information

I, _____[Name of Client], whose Date of Birth is _____, authorize Monarch Counseling, PC, 620 N. 48th Street, Suite 202, Lincoln, NE 68504 to disclose to and/or obtain from:

Name of Individual:	Organization:
Address:	Phone Number:

Information to be Disclosed from Monarch Counseling, PC:

- ❑ All Records
- ❑ Discharge/Transfer Summary
- ❑ Assessment/Evaluation/Diagnosis
- ❑ Treatment Plan or Summary
- ❑ Progress/Treatment Reports
- ❑ Continuing Care Recommendations
- ❑ Demographics
- ❑ Other_____

Information to be disclosed by above provider:

- ❑ All Records
- ❑ Discharge/Transfer Summary
- ❑ Assessment/Evaluation/Diagnosis
- ❑ Treatment Plan or Summary
- ❑ Progress/Treatment Reports
- ❑ Continuing Care Recommendations
- ❑ Demographics
- ❑ Other_____

Reason for Disclosure

- ❑ Request of Patient
- ❑ Obtaining Past Treatment Records
- ❑ Collaboration of Care
- ❑ Legal Purposes
- ❑ Consultation and/or Treatment
- ❑ Other_____

I understand that this will include information relating to (check if applicable):

- ❑Acquired Immunodeficiency Syndrome (AIDS) or infection with Human Immunodeficiency Virus (HIV)
- ❑Mental Health Information
- ❑Mental Health Joint Counseling Sessions (Please note that an Authorization Form must be obtained from all individuals present during such sessions.)
- ❑Psychotherapy notes (A separate Authorization Form must be signed for disclosure of psychotherapy notes)
- ❑Treatment for alcohol and/or drug abuse

Expiration: Unless sooner revoked, this authorization expires on the following date: _____ or one year from the date signed. (whichever is sooner)

Form of Disclosure: Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

By completing this authorization form, I agree that I understand:

• I have the right to revoke this authorization at any time. Revocation must be made in writing and presented or mailed to Monarch Counseling, PC, 620 N. 48th St, Suite 202, Lincoln, NE 68502. Revocation will not apply to information that has already been disclosed in response to this authorization.

• Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on whether I sign this authorization.

• Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules; however, Alcohol, Chemical and Drug Abuse patient records which are disclosed will be accompanied by a written statement as required by law prohibiting further disclosure except as allowed by law.

•I hereby release Monarch Counseling, its staff, or designee, from all legal liability that might arise from their release of the information or redisclosure of the information by the recipient.

SIGNATURES

Client:	Date:
Parent/Guardian/Personal Representative:	Date:
Signature of Witness:	Date: