HartsSpace
Mental Health & Nutrition

Type of Information to be Disclosed:

Client: _____

Birthdate: _____ SSN: _____

HEREBY AUTHORIZES HartsSpace, Katie Hart, MS, LMHC, CN

□ To Disclose To □ To Obtain From

Name of Person: _____

Organization: _____

Address: _____

City/State/Zip: _____

Phone: _____

The following specific information to be disclosed:

- ❑ General Assessment Information
- ❑ Treatment plans/therapy notes/goals
- ❑ Alcohol and/or drug evaluation
- ❑ Medical treatment recommendations
- ❑ CPS/DSHS reports
- ❑ Other_____
- □ Identifying information
  - □ Dates of service
- □ School records/contact with school counselor
  - □ Psychological evaluations/assessments
  - □ Family involvement in treatment

Purpose for Use or Disclosure:

- ❑ At client's request
- ❑ To coordinate/plan treatment
- ❑ Other_____
- □ Ongoing exchange of information

Conveyance of Information: □ Mail/Courier □ Telephone □ Electronic Data Transfer/Fax □ Individual

Revocation / Re-Disclosure:
It is my understanding that this authorization can be revoked in writing at any time, except to the extent that substantial action may have already been taken in reliance on it. Unauthorized re-disclosure by recipient is a potential risk.

Duration:
If not previously revoked, this authorization will expire _____
_____
(Law requires specification of date, event, or condition)

Signature:
Signature below authorizes use and/or disclosure of protected health information in accordance with the foregoing from the date of signature. I understand that I have the right to refuse to sign this authorization and that my refusal may condition treatment or payment.

_____
Signature (patient / parent / guardian / other legal representative for healthcare decisions) *Date*

Witness: _____ Date: _____