

Authorization for Exchange of Information

I, _____ (Date of Birth _____),
authorize **Kimberly Knowlton-Young, LICSW** to disclose to and/or obtain from:

_____ the following
information:
[Person or Title of Person or Organization]

Description of Information to be Disclosed: (Patient/Client should initial each item to be disclosed)

- | | |
|---|---|
| _____ Assessment | _____ Educational Information |
| _____ Diagnosis | _____ Discharge/Transfer Summary |
| _____ Psychosocial Evaluation | _____ Continuing Care Plan |
| _____ Psychological Evaluation | _____ Progress in Treatment |
| _____ Psychiatric Evaluation | _____ Demographic Information |
| _____ Treatment Plan or Summary | _____ Psychotherapy Notes* |
| _____ Current Treatment Update | (*Cannot be combined with any other disclosure) |
| _____ Medication Management | _____ Other _____ |
| Information | _____ All of the above |
| _____ Presence/Participation in Treatment | _____ |
| _____ Nursing/Medical Information | _____ |

Purpose

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services.

If the purpose is other stated above, please specify:

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to **Kimberly Knowlton-Young, LICSW** at PO Box 1161, Norwich, VT 05055. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration

Unless sooner revoked, this authorization expires on the following date: _____ or one-year from date of signing.

Conditions

I further understand that **Kimberly Knowlton-Young, LICSW** will not condition my treatment on whether I give authorization for the requested disclosure.

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.

Re-disclosure

I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be re-disclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections.

I will be given a copy of this authorization for my records.

Signature of Patient/Client Date

Signature of Parent, Guardian or Personal Representative Date

Signature of Second Parent, Guardian or Personal Representative Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.).

_____ Check here if patient/client refuses to sign authorization

Signature of Clinician Date