Beth Dilling, MA, NCC, LMHC

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Authorization for Mutual Disclosure of Protected Health Information

Type of Information to be Disclosed:

I hereby authorized Beth M. Dilling, MA, NCC, LMHC, to disclose and/or receive information related to my medical condition, including without limitation, information regarding my mental health or chemical dependence/substance abuse conditions and treatment.

Purpose of Disclosure/Exchange:

☐ At client's request ☐ Coordinate Treatment ☐ Other _____

Recipients of protected health information: Beth M. Dilling, MA, NCC, LMHC and

_____
Addressee(s) *Institutional Class, Group or Other Affiliation*

_____
Business Phone *Fax* *Address* *City* *State* *Zip*

Conveyance of Information: ☐ Telephone ☐ Fax/Electronic Data Transfer ☐ Mail ☐ Face to Face

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, including provision of health care services requiring subsequent disclosure to effect payment. Unauthorized re-disclosure by recipient is a potential risk.

Duration:

If not previously revoked, this authorization will expire: _____

Specific Limitation:

Except as to third-party payers, this authorization does not include disclosure for future health care services received more than ninety (90) days from date of last signature.

Conditions:

I understand that I have the right to refuse to sign this authorization; however, I also understand that refusing to do so may condition treatment by Beth M. Dilling.

Signature:

This authorization covers protected health information pertaining to _____ _____
Name *Date of Birth*

Signature below authorizes use and/or disclosure of protected health information in accordance with the foregoing from the date of signature (initial or renewal). I understand that I have the right to refuse to sign this authorization and that my refusal will not condition treatment or payment.

_____ _____ _____ _____
Signature (patient if over 12 years old) *Date* *Renewal Signature* *Date*

_____ _____ _____ _____
Renewal Signature *Date* *Renewal Signature* *Date*

Note to Recipient: This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2) and/or state law. The information received pursuant to this document is confidential and the recipient is prohibited from making further disclosure of this information to any other person or entity, or use it for any purpose other than as authorized herein, without the written consent of the person to whom it pertains or as otherwise permitted by law. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug patients.