The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time ("HIPAA").

1. Tell your mental health professional if you don't understand this authorization, and they will explain it to you.
2. You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to your mental health professional and your insurance company, if applicable.
3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment, make payment, or affect your eligibility for benefits. If you refuse to sign this authorization, and you are in a research-related treatment program, or have authorized your provider to disclose information about you to a third-party, your provider has the right to decide not to treat you or accept you as a client in their practice.
4. Once the authorization about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA.
5. If this office initiated this authorization, you must receive a copy of the signed authorization.
6. Federal law protects records that identify a person as having applied for or received services related to substance use disorder under, including alcohol or drug use treatment ("SUD") a special federal law (42 C.F.R. Part 2) that provides extra privacy safeguards. These special protections apply only if the records were created by a federally assisted (including accepting Medicare or Medicaid) substance use disorder treatment program, or I receive protected SUD treatment records from such a program. SUD records cannot be used or disclosed without your written permission ("authorization") unless federal and state law allows it. Not all mentions of alcohol or drug use in your record are covered by this special law. If your records are protected under the special SUD law: (1) I will not share them without your written permission except in limited situations allowed by law. (2) Your written permission may allow future sharing for treatment, payment, and healthcare operations as described below. (3) Anyone who receives these protected records is generally not allowed to share them again without proper authorization.
7. HIPAA provides special protections to certain medical records known "Psychotherapy Notes" also called Process Notes. All Psychotherapy Notes recorded on any medium (i.e. paper, electronic) by mental health professionals must be kept by the author and filed separated from the rest of the client's medical records to maintain a higher standard of protection. "Psychotherapy Notes" are defined under HIPAA as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, couple, or family counseling session and that are separate from the rest of the following: (a) medication prescription and monitoring, (b) counseling session start and stop times, (c) the modalities and frequencies of treatment furnished, (d) the results of clinical tests, and (e) any summary of: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date. Emails, texts, and other communication are part of your medical record. In order for a medical provider to release "Psychotherapy Notes" to a third party, the client who is the subject of the Psychotherapy Notes must sign an authorization to specifically allow for the release of Psychotherapy Notes. <u>Such authorization must be separate from an authorization to release other medical records.</u>
8. In Florida, a mental health provider may provide a Summary of Treatment instead of providing the full therapy records if the treatment provider believes the contents could reasonably be expected to cause substantial harm to the patient or another person.
9. If the couple or family is the client, both or all parties must sign a Disclosure Authorization Form giving written permission for any records to be released to one party or a 3rd party.

Client's Full Name: _____

Date of Birth: _____/_____/_____ Date Authorization Initiated: _____/_____/_____

Authorization Initiated By:

❑ Me, the client ❑ Current Treatment Provider _____

❑ Dr. Crystal Hollenbeck ❑ Other _____

I authorize Dr. Crystal Hollenbeck, LMHC to ❑ release, ❑ obtain, and/or ❑ discuss (written and/or verbal communication) the following information: Please choose A Summary or A Copy and then check the box you understand what may be included.

❑ A Summary of Treatment

❑ A Copy of PHI Medical / Mental Health Records

❑ I understand a summary of treatment or copy of PHI records may include information from the following:

> Intake Forms, Court Documents, Medical, Mental Health, Developmental, Social, and Relationship History, Evaluations and Assessments, Dates of Treatment, Diagnostic Information, Treatment Plans, Treatment Goals, Treatment Progress, Therapeutic Modalities, Medication Prescription and Monitoring Information, Drug or Alcohol Abuse Treatment, Sexual Abuse Treatment, Emails, Text Messages, Therapeutic Referrals, and Termination Information.

I understand that this authorization may include disclosure of information relating to mental health treatment, alcohol/substance abuse treatment, and confidential HIV/AIDS related information. In the event that the health information described above includes any of these types of information, I specifically authorize the release of such information as indicated below:

> ❑ Mental Health Treatment ❑ Alcohol/Substance Abuse Treatment ❑ HIV Related Information

❑ Other _____

With the following:

Full Name(s): _____

Organization: _____

Address: _____State: _____ Zip code: _____

Email: _____Phone: _____

Purpose of Disclosure: The reason I authorize this release of information:

❑ Coordination of medical and mental health care between helping professionals

❑ Therapist Transition for continued mental health care

❑ My Request for _____

❑ Other (describe): _____

This Authorization will expire on _____/_____/_____, or upon my written request.

Authorization and Signature:

I authorize the release of my confidential protected health information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. I understand that Dr. Hollenbeck will release only the minimum amount of information necessary to fulfill a request and that I may inspect or receive a copy the information to be disclosed, as provided in CFR164.524 (with reasonable charge). I understand the information that is used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected health information. I understand Dr. Crystal Hollenbeck dba H3 Counseling, LLC will not be held liable for information disclosed to another party per my request.

Signature of the Client: _____ Date: _____