Associates at York, Inc. Authorization
Mental Health Treatment

I, _____, whose Date of Birth is_____,

authorize Associates At York, Inc. to disclose to and/or obtain from:

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

Description of Information to be Disclosed

(Patient/Client should check each item to be disclosed)

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

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 than marketing, sale of information, research or as specified above, please specify:
_____
_____.

Marketing

☐ If the purpose of this disclosure is for marketing purposes, please check this box and set forth the financial remuneration amount received by Associates At York, Inc. in exchange for disclosing the information. $_____

Sale of Information

☐ If the purpose of this disclosure is for sale, license to use or lease of the information, please check this box.

Research

☐ If the purpose of this disclosure is for research purposes, please check this box and identify the current and future research studies as well as whether each research study is conditioned upon execution of this authorization and the individual's ability to opt into each study.
_____

Revocation

I understand that I have the right to revoke this authorization, in writing, at any time by sending written notification to Associates At York, Inc. at 142 W. York St. Ste 915 Norfolk, VA. 23510. 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 as otherwise indicated: _____

Conditions

I further understand that Associates At York, Inc. will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me failure to sign this authorization may have the following consequences: Information will not be transferred or released to any other agency or outside party in regards to treatment with out signing this authorization.

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.

Redisclosure

I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed 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

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 Staff Witness Date