WHITE OAK Counseling and Recovery
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AUTHORIZATION FOR THE USE/DISCLOSURE/EXCHANGE OF CONFIDENTIAL/PROTECTED INFORMATION

I, _____, DOB _____ hereby authorize White Oak Counseling and Recovery to disclose, and exchange confidential/protected information about me in accordance with the terms and provision of this authorization as described below:

1. Format of the disclosure: ☐ Oral information ☐ Written information ☐ Faxed information

2. Recipient's Name, Agency, and/or entities whom I have authorized to request, receive and/or use confidential/protected information about me:

Name: _____ Address (if applicable): _____

Phone: _____ Fax (if applicable): _____

3. This authorization for disclosure/exchange of information is limited to the extent and nature of information identified below:

☐ Evaluation/Assessment Records and Information	☐ Medical/psychological records (covering dates from _____ to _____
☐ Treatment Planning & Services Records and Information	☐ Testing information
☐ Information on current status of services provided	☐ Admission/Discharge information
☐ Facilitate Family involvement	☐ Treatment Attendance
☐ Billing, Payment, and Scheduling Coordination	
☐ Other _____	

4. Purpose of Disclosure:

☐ To provide comprehensive care	☐ To facilitate treatment process
☐ To determine need for treatment	☐ To meet court requirements
☐ Billing, Payment, and Scheduling Coordination	☐ Exchange of all written and verbal health information pertinent to the coordination of my care and treatment

5. Personal Statements about this disclosure for confidential/protected information

- I acknowledge such information cannot be disclosed without my written informed consent unless otherwise provided by law. I further understand that such information to be disclosed may include treatment of Psychiatric, Substance Abuse, and HIV/AIDS related illnesses.
- I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain services/treatment.
- I understand that I may withdraw my authorization at any time and that such withdraw may not be effective to prevent disclosure of information previously authorized or stop previous action that has already been taken in reliance on this authorization.
- I understand that, if the person or entity receiving this information is not covered by the Federal Privacy Regulations, such information may no longer be protected from further disclosure (unless it is also covered by the Substance Abuse Confidentiality Act-42 CFR Part 2; further disclosure prohibited).
- My signature means that I have read this form and/or have had it read to me and explained in language I can understand. I know what information will be disclosed and give my voluntary consent to its release.
- I understand I have the right to inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights).
- I have been made aware of the White Oak Counseling and Recovery Privacy Practices. The statement included in this authorization is binding on White Oak Counseling and Recovery.
- **Effective Date of this Authorization is no longer than 1 year of the date stated below.**

_____ Date _____

Signature of ☐ Individual ☐ Guardian (type of guardian _____) ☐ Legal Representative

_____ _____

Print Name Signature of Witness

From _____ to _____

The authorization will expire once the purpose of this disclosure ceases to exist, but no later than one year from the original date of signing.

Note: Photocopy or facsimile of this document shall be as effective as the original.