



Authorization and Release for Mutual Exchange of Information

I, _____ [Insert Name of Patient/Client], whose Date of Birth is _____, authorize Nurturing Village, LLC to disclose to and/or obtain from:

Provider / Organization's Name

Address

Phone Number

the following information: (Patient/Client should initial 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 including IEP paperwork
- _____ 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.

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Elizabeth M Krotser, LCSW. I further understand that a revocation of the



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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: _____

Conditions

I further understand that Nurturing Village, LLC, 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.

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