Good Life Center for Mental Health, LLC

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

1. Client _____ Date Of Birth _____
   First MI Last

Address _____
Street Name

_____

Apartment, floor, unit

_____

City, State Zip Code

Client's Email _____ Client Mobile Phone _____

2. I hereby give permission for my therapist, (Name of Therapist), Good Life Center for Mental Health, LLC to:
   - □ Release protected health information
   - □ Obtain protected health information
   - □ Discuss protected health information

3. Person and/or organization that information/records are to be released to or obtained from:

Name _____ Telephone _____

Address _____ City/State _____

_____ Zip Code _____

Telephone _____ Fax _____

4. Purpose of disclosure:
   - □ Treatment Planning/Coordination of Services
   - □ Evaluation/Assessment
   - □ Court Proceedings
   - □ 3rd Party Payment
   - □ Other _____

5. Information to be disclosed:
   - □ Treatment Summary
   - □ Intake/Psychiatric Assessment
   - □ Psychological Evaluation
   - □ Dates of Attendance
   - □ Billing Information
   - □ Therapeutic Information for 3rd Party Payment
   - □ Other _____

6. Effective Period:

   This authorization for relates to information that covers the period of services from:

   - □ All past and present periods
   - □ Specific Dates: From _____ To _____

7. Expiration Date:

   This authorization only applies to information existing as of the date signed and will automatically expire 365 days from the date of my signature, unless I otherwise specify that this authorization will terminate on the following date _____

- I understand that my medical records are protected under N.J. regulations applicable to health care professionals and under the Federal Protected Health Information regulations.
- My authorization is voluntary. I understand that my treatment, payment, enrollment, or eligibility for benfits will not be based on whether I sign this authorization.
- Specific information to be disclosed in my medical record may include information regarding drug or alcohol use, counseling referrals, and/or a history of testing or treatment of acquired immune deficiency syndrome (AIDS) or related conditions.
- My health information may be subject to re-disclosure and no longer protected by Federal or State Statutes.
- I understand that I may revoke this authorization at any time by notifying Craig Springer, PhD in writing (at the address above). Please note that revocation will not cancel any action taken by Craig Springer, PhD based upon this original authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
- I am entitled to receive a copy of this authorization.

Client Signature _____ **Date** _____

Client Signature _____ **Date** _____

Client's Representative _____ **Date** _____

Witness Signature _____ **Date** _____

If signed by Client's Representative:

Printed Name: _____

Indicate your relationship to the client and/or reason/legal authority :

Client is: □ Minor □ Incompetant □ Disabled □ Diseased

Legal authority: □ Parent □ Legal Guardian □ Represenative of Deceased

Notice to Recipient of Information

Each dislosure made with the client's written consent must be accompanied by the written statement below: The current treatment record, has been disclosed to you from records whose confidentiality is protected by Federal and State Laws. Federal Regulation [42 CFR, Part 2] and N.J.S.A. 45:14b-28. Federal Regulation CFT-Part 2 prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. 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 the patient.