MOONEY AND ASSOCIATES, LLC
A GROUP PRACTICE IN MENTAL HEALTH AND WELLNESS

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Release of Information or Authorization

I, _____ _____
(Client Name) *(Date of Birth)*
authorize Mooney and Associates, LLC to obtain information from, and share information with:

Name of Person/Agency/Doctor/Hospital: _____

Address: _____

Phone: _____

Unless lined through, information may include:

- Assessment/Diagnosis/Family History
- Service Plans
- Treatment Summary and Recommendations
- Psychological Testing/Consultation
- Medical Information/Medications
- Drug/Alcohol History and Treatment
- Other: _____

Check only **one** to indicate the purpose for which information is to be released/authorized:

☐ Treatment, Operations or Payment (If checked, this form becomes a **Release** and *services can be refused* if client refuses to sign)

Specify: _____

☐ Other [e.g., Law (attorney, probation), Education (schools) or Social Services] (If checked, this form becomes an **Authorization** and under HIPAA rules, *services may not be conditioned or refused* if client refuses to signs)

Specify: _____

- I understand that, unless lined through, information to be released/authorized may include information regarding the following condition(s):
  - Drug Abuse
  - Alcoholism or Alcohol Abuse
  - Psychiatric Conditions/Treatment
  - HIV/Auto Immune Deficiency Syndrome (AIDS)
- I understand that if this is a **Release** for "Treatment, Operations and Payment" purposes, Mooney and Associates, LLC may withhold treatment, payment, enrollment or eligibility for benefits if I refuse to sign
- I understand that if this is an **Authorization** for "Other" purposes, Mooney and Associates, LLC may not condition treatment, payment, enrollment or eligibility for benefits on whether I

sign or not

- If the information to be released/authorized pertains to the diagnosis and treatment of alcoholism and drug abuse, I understand that the confidentiality of the information is protected by Federal Law 42.C.F.R. Part 2.
- I understand that there is potential for information to be disclosed, as a result of this release/authorization, to be re-disclosed by the recipient and therefore no longer protected by the HIPAA Privacy Regulation
- I understand that I may revoke this release/authorization at any time by giving written notice to Mooney and Associates, LLC, except to the extent that action has already been taken to comply with it. Without such revocation, this release/authorization will expire on: _____ ık, one year from the date of my signature, or as of the action or event of: _____
- I understand that I have a right to refuse to sign this form subject to the conditions noted above, or if I sign, I am entitled to a copy of the signed form.

Client Signature: _____ Date: _____

Printed Client Name: _____

Therapist Signature: _____ Date: _____

Notice To Whom This Information is Given

This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Law prohibits you from making further disclosure of this information without the specific written consent of the person to whom it pertains.

**A copy/facsimile of this release/authorization is as valid as the original.*

If applicable, an assessment of the minimum necessary amount of information required has been applied to this release/authorization.

Revocation of Release/Authorization

I hereby revoke this Consent to Release/Authorization for Information.

Client Signature: _____ Date: _____

Printed Client Name: _____

Therapist Signature: _____ Date: _____