

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

The purpose of this form is to authorize **Aaron Scharenberg, LCPC, at Wellspring Counseling LLC, 310 W. Central Suite L, Andover, Kansas 67002** to share protected health information with the identified third party for the purposes of treatment, payment, and health care operations. If you refuse to authorize any such disclosure, complete the box labeled "Restriction on Disclosure." Otherwise, please complete the form as indicated.

MEMBER:

 Last Name First Name MI Date of Birth

THIRD PARTY:

 Organization/Individual Name

 Address

 Telephone/Fax

I authorize the Aaron Scharenberg, LCPC at Wellspring Counseling LLC to (check all that apply):

release to obtain from discuss with

the third party identified above the specified protected health information listed below for purposes of treatment, payment, and health care operations.

CHECK EACH APPLICABLE ITEM:

- | | |
|---|---|
| <input type="checkbox"/> Admission Evaluation Report
<input type="checkbox"/> Diagnosis Only
<input type="checkbox"/> Treatment Plan(s)
<input type="checkbox"/> Psychiatric Consultation Report
<input type="checkbox"/> Psychological Evaluation Report
<input type="checkbox"/> Discharge Summary
<input type="checkbox"/> Progress Review(s)
<input type="checkbox"/> Alcohol and Drug Treatment Information | <input type="checkbox"/> Hospitalization Screening
<input type="checkbox"/> Progress Notes from _____ to _____
<input type="checkbox"/> Medical Reports
<input type="checkbox"/> Legal Reports
<input type="checkbox"/> Education Reports
<input type="checkbox"/> HIV/AIDS Information
<input type="checkbox"/> Other: _____ |
|---|---|

This authorization shall remain in effect until _____ (date) at which time this authorization expires, but no later than one year from the date listed below. If this item is left blank, the authorization shall remain effective for one year from the date listed below.

I understand that enrollment, eligibility, payment, or treatment is not conditioned upon the execution of this authorization. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations. I understand that fees may be charged for preparing and sending copies of records. I understand that I may revoke this authorization at any time (except to the extent that action has been taken in reliance upon it) by providing verbal or written notice of revocation to Wellspring Counseling LLC / Aaron Scharenberg.

 Signature of Member/Member Representative Date

 Printed Name of Member Representative and Relationship to Member Representative Address and Phone Number

 Signature of Witness

RESTRICTION ON DISCLOSURE: The sharing of protected health information between any third party who has or is treating the Client and the Wellspring Counseling LLC/ Aaron Scharenberg for the purposes of treatment, payment, or health care operations is not authorized.

 Signature of Member/Member Representative Date

 Printed Name of Member Representative and Relationship to Member Representative Address and Phone Number

 Signature of Witness