Client Name:_____
MR#_____

Woodward Community Based Services

WCBS worker_____

Referral Form

Date of referral: _____

☐BCLIAISON ☐PEER SUPPORT ☐FAMILY PEER SUPPORT ☐SUBSTANCE ABUSE ☐EVAL ☐ART
☐ BHIS ☐SAL ☐THERAPY ☐REENTRY ☐ O.S.O.T. ☐ ☐RACKING& MONITORING

Name:_____ DOB:_____ Age:_____ Gender:_____ Race:_____ Title XIX:_____

SS#:_____ Religion:_____ Preferred Language/Communication:_____ School/Employer:_____

Current placement/residence:_____ Address:_____

Client phone number/contact number: _____ Email:_____

Guardian(s)_____ Phone ( )_____ Address:_____

Guardian Religion:_____ Preferred Language:_____ Email:_____

Mother:_____ Phone( )_____ Address:_____

Father:_____ Phone( )_____ Address:_____

Emergency Contact:_____ Phone( )_____ Relationship to Client:_____

Referral Source:_____ Phone ( )_____ Agency_____
Funding Source?: _____ Private Pay?:_____ Sliding Fee Scale?:_____

Medical Conditions: _____ Impairments (If Any):_____ Allergies_____
Medications (Include Usage and Duration):_____
Primary Care Physician:_____ Diagnosis:_____

Supplemental Services: (Please include services for all siblings as well as client, examples: IEP, therapy, med management, etc.)

_____

_____

Behaviors

Behavior of Concern	How Often Behavior Occurs	Severity of Behaviors 1 (lowest) to 5 (highest)	Triggers	Coping Mechnaisms

Treatment History (If there is no history please write none)

Provider-Agency	Type of Service	Dates of Service

Approved Contacts

First & Last Name	Relationship	Approved By

Unapproved Contacts/Unsafe Contacts? _____

_____

Are there any environmental safety/security concerns in the home for the WCBS worker?_____

☐Adequate lighting? ☐Loose Animals ☐Loitering outside home entrance ☐Weapons ☐Substances

Woodward Community Based Services
Insurance Benefit/Patient Demographics

Requesting Admin: _____
Provider name if existing: _____
☐New Client ☐Existing Client
☐MH ☐SA ☐ FGC ☐PSS ☐HAB ☐BHIS ☐Other

Client:
Last Name: _____ First Name: _____ DOB: ___/___/_____
SS#: _____
Address: _____ City/State/Zip: _____
Home #: _____ Cell: _____

Primary Policy Holder:
☐Same as Client (Skip to Insurance Section)
Last Name: _____ First Name: _____ DOB: ___/___/_____
SS#: _____
Address: _____ City/State/Zip: _____
Home #: _____ Cell #: _____

Insurance:
Please make a copy of the Insurance Cards, Front and Back & email to wcbsbilling@sequelyouthservices.com

Insurance Company: _____ Group #: _____
ID #: _____ Phone #: _____
Benefit Year (Mark One): _____ Calendar _____ Other: _____
Deductible: **Individual $**_____ **Family $** _____ N/A ____ **Met $**_____
Coinsurance: _____ Y _____ N Co-Pay: $_____
Visit Limit:
☐____# Per Benefit Year ☐ Auth after _____ Visit ☐No Limit
Initial Authorization #: _____ Validation Dates: ___/___/___ to ___/___/___
Visits _____
Authorizing Entity: _____ Phone: _____ Fax: _____

Secondary Insurance:
Please make a copy of the Insurance Cards, Front and Back & email to wcbsbilling@sequelyouthservices.com

Insurance Company: _____ Group #: _____
ID #: _____ Phone #: _____
Benefit Year (Mark One): _____ Calendar _____ Other: _____
Deductible: **Individual $**_____ **Family $** _____ N/A ____ **Met $**_____
Coinsurance: _____ Y _____ N Co-Pay: $_____

Notes/Exclusions: _____
_____

☐LMHC, LISW, LMSW, OR MD Only ☐Not Allowed

Client Name:_____
MR#_____

Woodward Community Based Services WCBS worker_____

Referral Form Date of referral: _____

Insurance Information

Please provide a copy of your insurance card(s) prior to your appointment or bring a copy with you for your intake.

Primary Insurance Coverage: _____ Phone Number:_____
Name of Insured:_____ Insured DOB:___/___/_____
Relationship to Insured:_____ Insured Employer:_____
Policy #:_____ Group #:_____
Effective Date:___/___/_____

Secondary Insurance Coverage: _____ Phone Number:_____
Name of Insured:_____ Insured DOB:___/___/_____
Relationship to Insured:_____ Insured Employer:_____
Policy #:_____ Group #:_____
Effective Date:___/___/_____

In signing this form, I acknowledge that I have disclosed ALL insurance information to Woodward Community Based Services. I also acknowledge that I may be billed for unpaid services with Woodward Community Based Services and any independent agency involved for my continuum of my care that may occur.

Signature: _____ Date:_____

Notes:

For further information about Woodward Community Based Services and programs, please check out the website: wcbscares.com or contact us at wcbs@sequelyouthservices.com.

Woodward Community Based Services
611 5th Ave.
Des Moines, IA 50310
515-274-9607

Adolescent Informed Consent Form for Telemental Health Services

Privacy of Information Shared in Counseling/Therapy:
Your Rights and My Policies

What is Telemental Health and when is it used?

Telemental health is used when mental health staff cannot be physically present with you to evaluate your mental health needs, if appropriate, prescribe medications. Mental health staff may be present at another location and available to serve you through available technology.

How does Telemental health work?

You will be in a private room either by yourself, with a friend, family member, or staff person. The room will have a computer with a video camera. The mental health staff will also be in a private room but at another location with the same type of equipment.

What happens if I choose not to consent to Telemental health services?

If you choose not to consent to Telemental health services, we will be unable to provide you with convenient and a readily available service.

Benefits to using Telemental health services

- Brings care to the patient
- Increases access to care
- Reduces travel time and costs
- Improves satisfaction with the health care system
- Reduces delays in care
- Enables continuity of care
- Re-conceptualizes the delivery of care
- Reduces stigma

Risks to using Telemental health services

- Possibility of technology failure and alternate methods of service delivery
- Anticipated response time
- Time zone differences
- Cultural and/ or language differences that may affect delivery of services

- Possible denial of insurance benefits

What to expect:

The purpose of meeting with a counselor or therapist is to get help with problems in your life that are bothering you or that are keeping you from being successful in important areas of your life. You may be here because you wanted to talk to a counselor or therapist about these problems. You may be here because your parent, guardian, doctor or teacher had concerns about you. When we meet, we will discuss these problems. I will ask questions, listen to you and suggest a plan for improving these problems. It is important that you feel comfortable talking to me about the issues that are bothering you. Sometimes these issues will include things you do not want your parents or guardians to know about. For most people, knowing that what they say will be kept private helps them feel more comfortable and have more trust in their counselor or therapist. Privacy, also called confidentiality, is an important and necessary part of good counseling.

As a general rule, I will keep the information you share with me in our sessions confidential, unless I have your written consent to disclose certain information. There are, however, important exceptions to this rule that are important for you to understand before you share personal information with me in a therapy session. In some situations, law requires me or by the guidelines of my profession to disclose information whether or not I have your permission. I have listed some of these situations below.

Confidentiality cannot be maintained when:

>You tell me you plan to cause serious harm or death to yourself or someone else, and I believe you have the intent and ability to carry out this threat in the very near future. I must take steps to inform a parent or guardian of what you have told me and how serious I believe this threat to be. I must make sure that you are protected from harming yourself.

>You are doing things that could cause serious harm to you or someone else, even if you do not *intend* to harm yourself or another person. In these situations, I will need to use my professional judgment to decide whether a parent or guardian should be informed.

>You tell me you are being abused-physically, sexually or emotionally-or that you have been abused in the past. In this situation, I am required by law to report the abuse to the Iowa Department of Human Services.

>You are involved in a court case and a request is made for information about your counseling or therapy. If this happens, I will not disclose information without your written agreement *unless* the court requires me to. I will do all I can within the law to protect your confidentiality, and if I am required to disclose information to the court, I will inform you that this is happening.

APPOINTMENTS
Appointments will ordinarily be 40-50 minutes in duration, once per week at a time we agree on, although some sessions may be more or less frequent as needed. The time scheduled for your

appointment is assigned to you and you alone. If you need to cancel or reschedule a session, I ask that you provide me with 24 hours' notice.

Communicating with your parent(s) or guardian(s):

Except for situations such as those mentioned above, I will not tell your parent or guardian specific things you share with me in our private therapy sessions. This includes activities and behavior that your parent/guardian would not approve of — or would be upset by — but that do not put you at risk of serious and immediate harm. However, if your risk-taking behavior becomes more serious, then I will need to use my professional judgment to decide whether you are in serious and immediate danger of being harmed. If I feel that you are in such danger, I will communicate this information to your parent or guardian. You can also contact Joint Commission at 1-800-994-6610 or email at complaint@jointcommission. Joint Comissions's fax number is 630-792-5632.

Even if I have agreed to keep information confidential – to not tell your parent or guardian – I may believe that it is important for them to know what is going on in your life. In these situations, I will encourage you to tell your parent/guardian and will help you find the best way to tell them. In addition, when meeting with your parents, I may sometimes describe problems in general terms, without using specifics, in order to help them know how to be more helpful to you.

Communicating with other adults:

School: I will not share any information with your school unless I have your permission and permission from your parent or guardian. Sometimes I may request to speak to someone at your school to find out how things are going for you. In addition, it may be helpful in some situations for me to give suggestions to your teacher or counselor at school. If I want to contact your school, or if someone at your school wants to contact me, I will discuss it with you and ask for your written permission. A very unlikely situation might come up in which I do not have your permission but both I and your parent or guardian believe that it is very important for me to be able to share certain information with someone at your school. In this situation, I will use my professional judgment to decide whether to share any information.

Doctors: Sometimes your doctor and I may need to work together; for example, if you need to take medication in addition to seeing a counselor or therapist. I will get your written permission and permission from your parent/guardian in advance to share information with your doctor. The only time I will share information with your doctor even if I do not have your permission is if you are doing something that puts you at risk for serious and immediate physical/medical harm.

* * * * *

Adolescent Consent Form
&
Parent Agreement to Respect Privacy

Adolescent therapy client:

Signing below indicates that you have reviewed the policies described above and understand the limits to confidentiality as well as the risks and benefits of telemental health. If you have any questions as we progress with therapy, you can ask your therapist at any time.

Minor's Signature _____ Date_____

* * *

Parent/Guardian:

_____ I understand that I will be informed about situations that could endanger my child. I know this decision to breach confidentiality in these circumstances is up to the therapist's professional judgment and may sometimes be made in confidential consultation with her consultant/supervisor.

Informed Consent to Treatment.

By placing my initials next to the following statements, I am voluntarily consenting to telemental health services provided by WCBS for my child. My initials also represent that I acknowledged my rights and my child's rights.

_____ I have chosen to have my child receive telemental health treatment services and understand I or my child may terminate these services at any time.

_____ I understand there is no assurance that my child will feel better.

_____ I understand that during the course of my treatment, material may be discussed that will be upsetting in nature and this may be necessary to resolve my child's problems.

_____ I understand that records and information collected about my child will be held or released in accordance with federal and state laws regarding confidentiality of such records and information.

_____ I understand that state and local laws require that my child's therapist report all cases of suspected abuse or neglect of minors or vulnerable adults.

_____ I understand that state and local laws require that my child's therapist report all cases in which there exists a danger to self or others.

_____ I understand that there may be other circumstances in which the law requires my child's therapist to disclose confidential information.

_____ I understand that I or my child may be contacted by my health plan to ensure continuity and quality of my treatment and/or after the completion of treatment, to assess the outcome of treatment.

Parent Signature _____ Date_____

Parent Signature _____ Date_____

Therapist Signature _____ Date_____

NOTICE OF PRIVACY PRACTICES

"THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY."

A. Introduction:

As part of your health care, Woodward Community Based Services originates and maintains numerous medical, billing, and other related records which contain information identifying you and describing your health history, symptoms, test results, diagnosis, treatment, and any plans for future care. This notice describes how this information may be used and disclosed by the Facility, as well as your rights and the Facility's duties with respect to such information.

B. Your Health Information Rights:

Although all records relating to the treatment you receive at the Facility are the property of the Facility, you have the following rights with respect to your health information:

- The right to request restrictions on certain uses and disclosures of your health information as provided by 45 C.F.R. 164.522. The Facility is not required to agree to any requested restriction.
- The right to obtain a copy of this Notice upon request.
- The right to inspect and obtain a copy of your health information as provided in 45 C.F.R. 164.524.
- The right to amend your health information as provided in 45 C.F.R. 164.526.
- The right to obtain an accounting of disclosures of your health information as provided in 45 C.F.R. 164.528. A Request for Accounting of Disclosures of Health Information must be made on the Facility's form. Copies of these forms are available at the Facility.
- The right to receive confidential communications of your health information as provided in 45 C.F.R. 164.522(b), as applicable.
- The right to receive notifications of breaches of unsecured PHI as provided in 45 C.F.R. 164.520(b)(1)(v)(A)).

You may exercise any of these rights by contacting the Facility representative listed below.

C. Facility Responsibilities:

The Facility is required by law to maintain the privacy of your health information and to provide you with a notice as to the Facility's legal duties and privacy practices with respect to your health information. The Facility is also required to abide by the terms of this Notice, as it may be revised from time to time.

The Facility reserves the right to change the terms of this Notice and to make any revisions to the Notice effective for all your health information that the Facility maintains. Should the Facility change the terms of this Notice it will either hand-deliver or mail you a revised notice as well as post the revised notice in an area accessible to residents.

D. **For More Information or to Report a Problem:**

If you have questions or would like additional information, you may contact

___Darian Baker_____ at _____515-274-9607_____

If you believe your privacy rights have been violated, you can file a complaint with

___Darian Baker _____ at ____515-274-9607_____

or with the Secretary of the Department of Health and Human Services without fear of retaliation for filing a complaint. All complaints must be in writing.

E. **Use and Disclosure of Your Health Information.**

As a general rule, the Facility may use or disclose your health information in the following ways:

Treatment: The Facility will use your health information in the provision and coordination of your healthcare. We may disclose all or any portion of your health information to other health care providers who have a legitimate need for such information in your care and continued treatment. The Facility also may disclose your health information to people outside the Facility who may be involved in your medical care after you leave the Facility, such as family members, clergy, and others used to provide services that are part of your care.

Family/Friends: In certain situations, the Facility may release health information about you to a friend or family member who is involved in your medical care, or to someone who helps pay for your care

Payment: The Facility may release health information about you for the purposes of determining coverage, billing, claims management, medical data processing, and reimbursement. Your health information may be released to an insurance company, third party payer or other entity (or their authorized representatives) involved in the payment of your medical bill and may include copies or excerpts of your medical record which are necessary for payment of your account. For example, a bill sent to a third party payer may include information that identifies you, your diagnosis, and the services and supplies provided to you. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Routine Healthcare Operations: The Facility may use and disclose your health information during routine healthcare operations, including, but not limited to, quality assurance, utilization review, medical review, internal auditing, accreditation, certification, licensing or credentialing activities of the Facility.

Facility Directory: In certain situations, the Facility may use your name and location in the Facility for directory purposes. This information may be provided to people who ask for you by name.

Business Associates: The Facility may disclose certain health information about you to business associates. A business associate is an individual or entity under contract with the Facility to perform or assist the Facility in a function or activity which necessitates the use or disclosure of health information. Examples of business associates, include, but are not limited to, consultants, accountants, lawyers, medical transcriptionist and third-party billing companies. The Facility requires the business associate to protect the confidentiality of your health information.

Marketing: The Facility may disclose certain contact information to a third party to provide marketing materials and information to you.

Regulatory Agencies: The Facility may disclose your health information to a health oversight agency for activities authorized by law, including, but not limited to, licensure, certification, audits, investigations and inspections. These activities are necessary for the government and other health oversight agencies to monitor the healthcare system, government programs, and compliance with civil rights.

Law Enforcement/Litigation: The Facility may disclose your health information for law enforcement purposes as required by law or in response to a valid subpoena or court order.

Public Health: As required by law, the Facility may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.

Victims of Abuse: The Facility may disclose your health information to government authorities, such as social services authorities or protective agencies, if the Facility reasonably believes that you are a victim of abuse, neglect, or domestic violence.

Workers Compensation: The Facility may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.

Required by Law: The Facility will disclose medical information about you when required to do so by law.

Coroners, Medical Examiners, Funeral Directors: In the event of your death, the Facility may release your health information to a coroner or medical examiner. This may be necessary,

for example, to determine a cause of death. The Facility may also release your health information to funeral directors as necessary to carry out their duties.

Organ Procurement Organizations: Consistent with applicable law, the Facility may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking or transplantation of organs for the purpose of tissue donation and transplant.

Research: The Facility may disclose your health information to researchers when their research has been approved by an institutional review board that has reviewed the research purpose and established protocols to ensure the privacy of your health information. Before disclosing any of your health information we will verify that the researchers have obtained your consent to participate in the study.

Appointment Reminders/Treatment Alternatives: The Facility may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Food and Drug Administration (FDA): The Facility may disclose to the FDA health information relative to adverse events with respect to food supplements, products, and product defects, or post- marketing surveillance information to enable product recalls, repairs, or replacement.

Avert Threat to Health or Safety: The Facility may disclose your health information if the Facility in good faith believes that disclosure is necessary to prevent serious harm to an individual or the public.

Government Functions: When appropriate, the Facility may disclose health information to serve certain governmental functions. The entities who may receive this information include, but are not limited to the military, intelligence agencies, and correctional institutions.

Fundraising: The Facility may contact you as part of our fundraising efforts.

Other Uses: Any other uses or disclosures of your health information will be made only with your written authorization. You may revoke an authorization, in writing, at any time except to the extent that the Facility has relied on your authorization.

F. The following uses and disclosures require authorization from you:
- Most uses and disclosures of psychotherapy notes (where applicable).
- Uses and disclosures of PHI for marketing purposes; and
- Uses and disclosures that constitute the sale of PHI.

G. **Confidentiality of Substance Abuse Treatment Records.**

Federal regulations (42 C.F.R. Part 2) provide special protection for the confidentiality of

certain alcohol and drug abuse treatment records. To the extent that the Facility maintains any records or other health information about you that is protected from disclosure by these regulations, the Facility will only disclose such information as permitted by these regulations.

H. **Mental Health Care Treatment Records.**

State law and/or regulations may provide special protection for mental health care treatment records. To the extent that the Facility maintains any records or other health information about you that is protected from disclosure by such state law and/or regulations, the Facility will only disclose such information as permitted by state law and/or regulations.

I. **Effective Date:**

The effective date of this notice is _____.
(Date)

I acknowledge that I have been provided a copy of the Facility's "Notice of Information Practices" which provides a description of the manner in which the Facility may use and disclose my protected health information. If I have any questions, I know that I have the right to contact Sequel and ask the Privacy Officer about my concerns.

_____ _____
Signature of Client Date

_____
Client's name (please print)

_____ _____
Signature of Parent or Guardian Date

_____ _____
Signature of Witness /Therapist /Counselor Date

COMMUNICATION FORM:

I wish to be contacted in the following manner.

☐ **Home Phone**

_____Okay to leave message with details

_____Leave a call back number only

☐ **Cell Phone**

_____Okay to leave message with details

_____Leave a call back number only

_____Okay to text

☐ **Work Phone**

_____Okay to leave message with details

_____Leave a call back number only

☐ **Written Communication**

_____Okay to mail to home address

_____ _____

Client (or Guardian) Signature Date

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

Patient Name	Date of Birth	Phone Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT,** except psychotherapy notes, and **CONFIDENTIAL HIV RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) or category of person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.

7. Name and address of Sequel Youth and Family Services facility/program to release this information:
Woodward Community Based Services, 611 5th Ave, Des Moines, IA 50309

8. Name and address of person(s) or category of person(s) to whom this information will be sent:

9 Specific information to be released:

- ☐ Medical Record from (insert date) _____ to (insert date) _____
- ☐ Psychiatric Assessment and Psychiatric Progress Notes (except psychotherapy notes)
- ☐ History and Physical
- ☐ Most recent discharge summary and Master Treatment Plan
- ☐ Testing results (lab, x-ray, EEG, EKG, etc.)
- ☐ Records sent to you by other health care providers
- ☐ Physician orders and progress notes
- ☐ Billing records
- ☐ Verbal conversations with family members: (name person) _____
- ☐ Verbal conversations with non-family members: (name person) _____
- ☐ Court testimony and related services
- ☐ Other: _____

Include: *(Indicate by Initialing)*

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

10. Reason for release of information:
- ☐ At request of individual
- ☐ Other:

11. If I do not specify a date or event in this box, this authorization shall expire 24 months from the date of my signature below.

12. If not the patient, name of person signing form:

13. Authority to sign on behalf of patient:

(If applicable, attach supporting documentation).

I understand that after I sign this Authorization I may receive a copy. I also understand that I may inspect or copy the information to be used or disclosed, as provided for in 45 C.F.R. § 164.524.

_____ Date: _____

Signature of patient or representative authorized by law.

AUTHORIZATION FOR RELEASE OF PSYCHOTHERAPY NOTES PURSUANT TO HIPAA

Patient Name	Date of Birth	Phone Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
2. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
3. Information disclosed under this authorization might be redisclosed by the recipient, and this redisclosure may no longer be protected by federal or state law.
4. THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 7(B).

5. Name and address of Sequel Youth and Family Services facility/program to release this information:

6. Name and address of person(s) or category of person(s) to whom this information will be sent:

7(a). Specific information to be released:

☐ Psychotherapy Notes from (insert date) _____ to (insert date) _____

☐ Entire Record of Psychotherapy Notes

☐ Other: _____

_____

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ I authorize _____

Initials — Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

_____

(Attorney/Firm Name or Governmental Agency Name)

8. Reason for release of information:	9. If I do not specify a date or event in this box, this authorization shall expire 24 months from the date of my signature below.
☐ At request of individual ☐ Other:	
10. If not the patient, name of person signing form:	11. Authority to sign on behalf of patient: (If applicable, attach supporting documentation).

I understand that after I sign this Authorization I may receive a copy. I also understand that I may inspect or copy the information to be used or disclosed, as provided for in 45 C.F.R. § 164.524.

_____ Date: _____

Signature of patient or representative authorized by law.