The Counseling Collaborative

Tara McKernan, M.Ed., LCPC-C
1489 State Highway 102, Bar Harbor, ME 04609
(207) 288-3388 (Phone & Fax)
Tara@tccmaine.com

Authorization for Disclosure of Protected Healthcare Information

Client Name: ____ Date: _________

Client Date of Birth: ___________________

I/We ____

Do by authorize Tara McKernan, M.Ed., LCPC-C to disclose to and/or obtain information from:

Contact Person: ____
Organization/Relationship: ____
Mailing Address: ____
Phone Number: ______________________________Fax Number:_________________________________

(Circle one one) Purpose of disclosure: **Treatment planning/ continuity of care**______: **other**__________________
____

Protected information NOT authorized: ____
____

I understand that I do not need to sign this form in order to receive services. I understand that this authorization expires a year from today's date or on the date of closure, determined by which comes first. I understand that I may withdraw my permission in writing ay any time except where provided by law. Unless otherwise specified, this consent to release information expires in one year of the date of initial signature.

I understand that (if applicable) my alcohol / drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 C.F.R. Part 2) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. parts 160 & 164 and cannot be disclosed or further re-disclosed by the designated recipient of this information unless expressly permitted by the written consent of the person to whom it pertains, or unless otherwise provided for in the regulations. I also understand that my behavioral health records are confidential and protected from unauthorized disclosure. I understand that if the person or entity that receives this information is not a health plan or health care provider covered by federal privacy regulations, the released information may be re-disclosed by the recipient and may no longer be protected by federal/state law. I understand that I may revoke this authorization/consent at any time by notifying the provider in writing, except to the extent that action has been taken in reliance on it. Thus, I understand that my revocation will not affect any actions taken by my provider before receiving my written revocation.

Client Signature: ____ Date: _______

Parent/Guardian Signature: _______________________________________ Date: ______

Parent/Guardian Signature: _______________________________________ Date: ______

Counselor: ____ Date: ______