COLLABORATIVE CARE
Behavioral Therapy
LLC

AUTHORIZATION FOR USE OF DICLOSURE OF PROTECTED HEALTH & CONFIDENTIAL INFORMATION

Client:_____ DOB:_____

Information about the other organization to which or from which information will be disclosed:

Organization:_____

Office Phone:_____ Fax:_____ Cell:_____

Name of Individual(s):_____

Address:_____ City:_____ State:_____ Zip:_____

☐ I am requesting that Collaborative Care Behavioral Therapy LLC release information to the above organization.
☐ I am requesting that the above organization release information to Collaborative Care Behavioral Therapy LLC.
☐ I do NOT authorize my information to be shared between CCBT and the entity above.

I hereby authorize the disclosure or release of the following information: (check all that apply)

☐ Social History
☐ Test Results & Reports
☐ Psychotherapy Records
☐ Progress Reports
☐ Vocational Evaluation Reports
☐ Medical/Dental Records
☐ Intake Assessments & Notes
☐ Immunization Records
☐ Treatment Plans
☐ Educational Records
☐ Court Records
☐ Discharge Summaries
☐ Other:_____

To Collaborative Care Behavioral Therapy LLC, 1235 Hardin Pike Rd., Wapakoneta, OH 45895.

☐ This information may be disclosed to and used by all Collaborative Care Behavioral Therapy staff providing Direct services to the client following minimum necessary provisions.
☐ Use or disclosure of the information is limited:_____

Protected Health Information is being used or disclosed for the following purposes:

☐ At the request of the Client, Parent, or Guardian.
☐ Other:_____

All matters relating to this individual which are privileged and confidential by law will be treated as such by the personnel/agencies. The information specific above shall be released only among the mentioned personnel/agencies unless otherwise required by law or court. I understand that I have the right to revoke this authorization at any time by sending or delivering written notification to Collaborative Care Behavioral Therapy LLC. I understand that a revocation is not effective to the extent that Collaborative Care Behavioral Therapy LLC has already acted on the authorization. I understand that once this authorization is acted upon, the receiving party may be under no legal obligation to maintain the confidentiality of health information and could in turn disclose it to one or more other parties. By Federal Law, Collaborative Care Behavioral Therapy LLC shall not condition the provision of the health care services on whether I sign this document, except as outlined in Collaborative Care Behavioral Therapy LLC policies.

This authorization shall expire one year from date of authorization or until otherwise revoked.

_____	_____	_____
Name of Client or Parent/Guardian	Signature of Client or Parent/Guardian	Date