Li Lin Hally, LCSW

Serving Individuals, Teens, Families & Groups

Release of Information

I, _____ [Name of Client], whose Date of Birth is _____,

Authorize Li Lin Hally, LCSW to disclose to and/or obtain from:

_____ the following information:

[Name of Person or Title of Person or Organization]

_____ Assessment
_____ Diagnosis
_____ Psychosocial Evaluation
_____ Psychological Evaluation
_____ Psychiatric Evaluation
_____Treatment Plan or Summary
_____Current Treatment Update
_____ Medication Management Information
_____Presence/Participation in Treatment
_____Nursing/Medical Information
_____Educational Information
_____ Discharge/Transfer Summary
_____ Continuing Care Plan
_____Progress in Treatment
_____ Demographic Information
_____ Other _____
_____ Other _____

Purpose

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services. If other purpose, please specify: _____
_____

Revocation

I understand that I have a right to revoke this authorization, in writing at any time by sending written notification to Li Lin Hally, LCSW. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration

Unless sooner revoked, this consent expires on the following date: _____ or as otherwise indicated: _____

Form of Disclosure

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Redisclosure

I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections.

_____

Signature of Patient/Client Date

_____

Signature of Parent, Guardian or Personal Representative Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, minor, etc.)