Authorization for Exchange of Information

I, _____ (Date of Birth _____), authorize **Kimberly Knowlton-Young, LICSW** to disclose to and/or obtain from: _____
[Person or Title of Person or Organization] the following information:

Description of Information to be Disclosed: (Patient/Client should **initial** each item to be disclosed)

_____ 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
_____Psychotherapy Notes*
(*Cannot be combined with any other disclosure)
_____Other_____
_____All of the ab

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 the purpose is other stated above, specify:___**none**_____

Revocation: I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to **Kimberly Knowlton-Young, LICSW** at 20 West Park St. Lebanon, NH 03766. 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 authorization expires on the following date: _____ or one-year from date of signing.

Conditions: I further understand that Kimberly Knowlton-Young, LICSW will not condition my treatment on whether I give authorization for the requested disclosure.

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.

Re-disclosure: I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be re-disclosed 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. I will be given a copy of this authorization for my records.

Signature of Patient/Client: _____ Date_____

Signature of Parent, Guardian or Personal Representative: _____ Date_____

Signature of Second 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, etc.): _____

_____Check here if patient/client refuses to sign authorization.

Signature of Clinician _____ Date_____

Kimberly Knowlton-Young, LICSW, 20 West Park, Lebanon, NH 03766
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