Professional Counseling, Diagnosis, and Mental Health Services with Life Coaching and Professional Development Options

Kurt LaRose MSW LCSW CHT

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AUTHORIZATION TO RELEASE and OBTAIN MEDICAL RECORDS / INFORMATION

Agency / Party Having Private Health Information:
Address:
City, State, Zip:
Telephone Number:
Verify Fax with Name / Date _____ Fax:

The Office of Kurt LaRose MSW LCSW CHT has requested that you release the medical records of _____, DOB: _____, by mail, phone, fax, or secure server email (***Secure Server Notes**: parties electing this option must contact the office of LaRose for the encrypted password server access point to communicate via the secure digital platform*). These records are requested for the **purpose of in-take, assessment, diagnosis, and treatment, including the coordination of care.** If necessary, please include an invoice for any charges to produce the records (up to amounts that are regulated by mental health records copying laws). The **date range for this records request** is approximate as the client and the practice are unsure of the exact dates of service within your organization. An approximate date range for this records request is FROM_____ TO_____ Please provide the requested information **listed and marked below**, in accordance with state and federal regulations.

___General Medical Records ___Problem List ___Diagnostic Test Reports / Diagnosis Information
___ History & Physical ___Most Recent ___All
___X-Ray Imaging Reports ___Most Recent ___All
___Laboratory Results
___Progress Reports
___Specific Test Results *
___Referral / Professional Consultation *
___Sexually Transmitted Diseases
___Alcohol/Drug Abuse Information / Tests
___Psychiatric/Psychology
___HIV/AIDS ___Tuberculosis
___Case Management Information / Discharge Planning
___ Billing Release (Only) *

___Other Information/Reasons (Specify / Explain*):

---------- AUTHORIZATION SUMMARY, EXPLANATIONS, RIGHTS, REVOCATIONS, REFUSALS, and LEGAL REFERENCES ----------

I understand that I am consenting to waive my confidentiality rights, as protected by standards of care, national associations, state and federal law, and I am doing so willingly. I have not been pressured, coerced, and I do not feel that I must in any way sign this authorization. The reasons for this request have been explained to me, and I agree with the above checked reasons, as explained to me. Questions I have about the reasons for this request have been explained to me, and I have been given the option to refuse this request. Refusing this request, if I elect to do so, is noted on this form as a matter of documenting both the request and the refusal of it. I understand that my refusal to provide consent will not affect the care I receive from the practice. Consent is not necessary to release private health information in the case of safety (life threatening situations and abuse, for example). In the case of legally mandated releases of information (such as court orders where oversight is provided as a condition of a case for example) I am providing my consent to comply with such orders. I am guaranteed protections regarding my private health information as specified in: the Privacy Act of 1974 (PL93-592), the Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information (Privacy Rule), Code of Federal Regulations (CFR) "Confidentiality of Alcohol and Drug Abuse Records", Code 42, Chapter 1, Subchapter A, Part 2 and also, the Florida Mental Health Act, Chapter 394.4615, "Clinical Records; Confidentiality". Further, I understand that Federal law (Code of federal regulations 42, part 2) prohibits recipients of confidential records requests, who receive the requested information, from making any further disclosure of said information without my specific written permission. Released information, once it has been sent/obtained, is shared in the organization and seen by other parties in order to effect the request and in order to effect care. This consent will automatically terminate one year from the signed date, if not otherwise previously revoked; I understand that I may revoke this authorization at any time.

_____ _____
Client/Patient Signature Date

_____ _____
Printed Name Relationship to Patient

_____ _____
Witness Signature Date

_____ _____
Witness Printed Name Date