Magnolia Counseling Solutions, LLC Authorization Mental Health Treatment (HIPPA Form)

I, _____[Name of Client], whose Date of Birth is_____ , authorize Magnolia Counseling Solutions, LLC (Magnolia) to disclose to and/or obtain from: (i) the insurance carrier(s) for which I have provided coverage information to Magnolia, and
(ii)_____
____ the following protected health information (as that term is used in HIPAA) [Insert Name of Primary Care Physician, Psychiatrist, Practice, or Organization]: **Description of Information to be Disclosed** (Client should check each item to be disclosed)

_____ Description of Care / Services Provided, Fees, & Charges Owed, & Other Information as is necessary to submit a claim to my insurer(s) and be paid _____ Client initials to indicate agreement for All information checked

_____ Assessment _____ Diagnosis _____ Verbal Communication _____ Treatment Plan or Summary

_____ Current Treatment Update _____ Medication Management Info _____ Participation in Treatment

_____ Discharge Summary _____ Progress in Treatment _____ Demographic Information _____ Other:_____

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. **IT IS NOT THE PURPOSE OF THIS AUTHORIZATION TO AUTHORIZE THE RELEASE OF THERAPY/THERAPIST (S) NOTES, AS DEFINED BY HIPAA. IF I WISH OR HAVE A NEED TO AUTHORIZE THE RELEASE OF THERAPY/THERAPIST (S) NOTES, I WILL EXECUTE A SEPARATE AUTHORIZATION AUTHORIZING THE SAME.** If the purpose is other than marketing, sale of information, research or as specified above, please specify: **Research:** If the purpose of this disclosure is for research purposes, please check this box and identify the current and future research studies as well as whether each research study is conditioned upon execution of this authorization and the individual's ability to opt into each study. **Revocation**: I understand that I have the right to revoke this authorization, in writing, at any time by sending written notification to an Officer at Magnolia Counseling Solutions LLC at 1565 Ebenezer Rd, Suite #135, Rock Hill, SC 29732. 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 (1) 180 days following last treatment, or (2) as otherwise indicated the following date: **Conditions:** I further understand that Magnolia will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences:TERMINATION OF SERVICES.

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 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, and acknowledge receiving a copy.

X(Client/Parent/Guardian/Signature)

Date

X (Signature of Staff Witness)

Date