AUTHORIZATION TO RELEASE/EXCHANGE INFORMATION

I, (name of patient) _____, with a date of birth of _____ (hereinafter "Patient") hereby authorize **New Paths Counseling, Katherine Bogushefsky MC, LPC**. **or Employees of New Paths Counseling** (hereinafter "Provider") to disclose/exchange mental health treatment information and records obtained in the course of psychotherapy treatment of Patient including, but not limited to HIPAA Protected Health Information (PHI), with/to:

_____

_____

I understand that the information to be released includes records in any form, and oral conversations with the Provider. I understand that I have a right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing. I understand that I have the right to refuse to sign this authorization. I understand that I have the right to revoke this authorization at any time unless Provider has taken action in reliance upon it. And, I also understand that such revocation must be in writing and received by Provider at 16515 S 40th St # 103Phoenix Az 85048 to be effective.

This disclosure of information and records authorized by Patient is required for the following purpose:

- r Coordination of treatment with another mental health professional involved in your care.
- r Coordination of treatment with another type of health professional involved in your care.
- r To obtain insurance or other third party benefits under a managed care agreement.
- r Coordination with another type of professional (e.g., attorney).
- r To obtain benefits of programs that are not health insurance related (e.g., SSI, SSD, private disability, etc.).

r Other _____

Such disclosure of written or oral conversations shall be limited to the following specific types of information:

- r Assessment, diagnosis, treatment plan, compliance, functionality, test results, and response to treatment.
- r Information pertaining to substance abuse or substance dependency.
- r Sensitive relationship issues, family dynamics, sexual issues, and other highly personal information. ***This information is contained in Psychotherapy Notes as defined by HIPAA. Authorization to release Psychotherapy Notes can not be combined with a release for other PHI on the same form.***

r Other _____

The specific uses of Protected Health Information (PHI) to be discussed or released are as follows

- r Coordination of response to psychotropic medications prescribed by a psychiatrist or other physician.
- r Coordination of other medical treatment with mental health, marital, or family treatment.
- r Coordination of marital or family treatment with individual treatment.
- r Case management and/or utilization review under a managed care agreement.
- r Review of treatment and/or functionality to obtain benefits of non-health-insurance related programs.

r Other _____

Patient understands that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule, although applicable Arizona law may protect such information.

This authorization shall remain valid until: _____

Patient's signature: _____ Date: _____

Witness (if necessary): _____ Date: _____