Shanna Holladay, MA, MFT
3323 Sacramento Street, San Francisco, CA 94118
(415) 339-1291

New Client Intake

Client Name	Street Address	City, State & Zip	Day Telephone Evening	Evening Telephone
			( )	( )

Client Date of Birth	Marital/ Relationship Status	How long in current relationship?	Education Level	

Who may we contact in an emergency?	
Name Address Phone Relationship	Name Address Phone Relationship

Social Security #	Driver's License Number	Employer Name , Address, & Telephone	May we contact you at home? At work? Work? Yes □ Home? Yes □
Insurance Company	**Primary Covered**	**Primary Covered Date of Birth**	**Insurance ID number**

Your Household Make Up?

Name	Age	Relationship	School (if child)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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TREATMENT CONSENT

LIMITS OF CONFIDENTIALITY STATEMENT

All information between practitioner and patient is held strictly confidential. There are legal
exceptions to this:

1. The patient authorizes a release of information with a signature.
2. The patient's mental condition becomes an issue in a lawsuit.
3. The patient presents as a physical danger to self (Johnson v County of Los Angeles, 1983).
4. The patient presents as a danger to others (Tarasoff v Regents of University of California, 1967).
5. Child or Elder abuse and/or neglect is suspected (Welfare & Institution and/or Penal Codes).

In the latter two cases, the practitioner is required by law to inform potential victims and legal authorities so that protective measures can be taken. All written and spoken material from any and all sessions is confidential unless written permission is given to release all or part of the information to a specified person, persons, or agency. If group therapy is utilized as part of the treatment, details of the group discussion are not to be discussed outside of the counseling sessions.

Initial here: _____

RELEASE OF INFORMATION

I authorize release of information to my Primary Care Physician, other health care providers, institutions, and referral sources for the purpose of diagnosis, treatment, consultation and professional communication. If I am an insured client, I further authorize the release of information for claims, certification, case management, quality improvement, benefit administration and other purposes related to my health plan.

Initial here: _____

TELEPHONE & EMERGENCY PROCEDURES

If you need to contact Shanna Holladay between sessions, please leave a message on the voice mail (415) 339-1291 and your call will be returned as soon as possible. During the week Shanna Holladay, MA, MFT, checks her messages frequently until 8pm. Shanna Holladay, MA, MFT checks the messages less frequently on weekends and holidays. If an emergency situation arises, please indicate it clearly in your message. If you need to talk to someone right away, you can call the 24-hour crisis line in Alameda County it is 1-800-309-2131 and in San Francisco it is 800-272-8255. If there is a life threatening emergency please call (911).

Initial here: _____

PAYMENTS & INSURANCE REIMBURSEMENT

If your service is covered by insurance you are responsible for obtaining prior authorization for treatment from your insurance carrier. I will bill your insurance, however, you are responsible for co-payment amounts and deductibles as set by your benefit plan. Clients are expected to pay any fees due at the end of each session unless other arrangements have been made. Telephone conversations, site visits, report writing and reading, consultation with other professionals, release of information, reading records, longer sessions, travel time, etc. will be charged at the my full hourly rate of $120, unless indicated and agreed otherwise. Please notify Shanna Holladay, MA, MFT if any problem arises during the course of therapy regarding your ability to make timely payments. **Missed appointments are not covered by your insurance and the charges associated with them are your responsibility**. At any time during treatment should I become ineligible for insurance coverage, I will notify the practitioner and understand I will become responsible for 100% of the bill. Please notify Shanna Holladay, MA, MFT if any problem arises during the course of therapy regarding your ability to make timely payments.

Initial here: _____

CANCELLATION

Since scheduling of an appointment involves the reservation of time specifically for you, a minimum of 24 hours notice is required for re-scheduling or canceling an appointment. Your full fee will be charged for sessions missed without such notification. **Insurance companies do not reimburse for missed sessions so you are responsible for the full fee your insurance company would reimburse.**

Initial here: _____

APPEALS AND GRIEVANCES-FOR INSURED CLIENTS

I acknowledge my right to request reconsideration (an Appeal) in the case that outpatient care is not certified. I understand that I can request an Appeal directly through my Health Plan and that I risk nothing in exercising this right. I also understand that I may submit a Grievance to my Practitioner at any time to register a complaint about my care or I may send the complaint directly to my Health Plan. My practitioner has access to information and forms to facilitate this. **(California Only)** I understand that the California Department of Corporations (DOC) is responsible for regulating health care services. The California DOC has a toll-free telephone number (**800-400-0815**) to receive complaints regarding health care plans. If I have a grievance I can contact my insurer and use the appeal and grievance process. If I need the DOC's help with a complaint involving an emergency appeal or with an appeal that has not has not been satisfactorily resolved by the plan, I can call the DOC's toll free telephone number.

Initial here: _____

HEALTH INSURANCE & CONFIDENTIALITY OF RECORDS

Disclosure of confidential information may be required by your health insurance carrier or HMO/PPO/MCO/EAP in order to process the claims. Shanna Holladay, MA, MFT, has no control or knowledge over what insurance companies do with the information she submits or who has access to this information. You must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk to confidentiality, privacy, or to future eligibility to obtain health or life insurance.

Initial here: _____

CONFIDENTIALITY OF E-MAIL, CELL PHONE AND FAXES COMMUNICATION

It is very important to be aware that e-mail and cell phone (also cordless phones) communication can be relatively easily accessed by unauthorized people and hence, the privacy and confidentiality of such communication can be easily compromised. E-mails, in particular, are vulnerable to such unauthorized access due to the fact that servers have unlimited and direct access to all e-mails that go through them. Faxes can be sent erroneously to the wrong number. Please notify Shanna Holladay, MA, MFT, at the beginning of treatment if you decide to avoid or limit in any way the use of any or all of the above-mentioned communication devices. Please do not use e-mail in an emergency situations.

Initial here: _____

Social Media Policy

Shanna Holladay, MA, MFT does not engage with clients in any way on social media sites. She discourages clients from posting in any way about their therapeutic process in order to best protect the client's confidentiality.

Initial here: _____

CONSULTATION

Shanna Holladay, MA, MFT may consult with other professionals regarding her clients; however, the client's name or other identifying information is never mentioned. The client's identity remains completely anonymous, and confidentiality is fully maintained.

Initial here: _____

CONSENT FOR TREATMENT

I authorize and request my practitioner to carry out psychological treatment and/or diagnostic procedures which now, or during the course of my treatment become, advisable. I understand the purpose of these procedures will be explained to me upon my request and that they are subject to my agreement. I also understand that that while the course of my treatment is designed to be helpful, my practitioner can make no guarantees about the outcome of my treatment. Further, the psychotherapeutic process can bring up uncomfortable feelings and reactions such as anxiety, sadness, and anger. I understand that this is a normal response to working through unresolved life experiences and that these reactions will be worked on between my practitioner and me.

Initial here: _____

I have read the above Agreement and Office Policies and General Information carefully; I understand them and agree to comply with them:

_____

Client name (print) **Date** **Signature**

_____

Client name (print) **Date** **Signature**

General Consent for Child or Dependent Treatment

I am the legal guardian or legal representative of the patient and on the patient's behalf legally authorize the practitioner/group to deliver mental health care services to the patient. I also understand that all policies described in this statement apply to the patient I represent.

_____

Patient Name (print)

_____

Signature of Legal Guardian/Legal Representative **Date**

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Insurance Agreement

I hereby agree that I have provided Shanna Holladay, MA, MFT, the correct information in regards to my insurance information. I also understand that my insurance will be billed each session and that if they do not pay I will become responsible for it. I also understand that Shanna Holladay, MA, MFT, has a 24 hour cancellation policy. My insurance does not pay for no-show/late cancellation fees. I understand that if I cancel an appointment with less than 24 hours notice that I am responsible for the full fee my insurance would reimburse.

I also authorize the release of any medical or other information necessary to process the claim for payment of services provided by Shanna Holladay, MA, MFT,. I understand that this information will include a diagnosis. I authorize payments to Shanna Holladay, MA, MFT, for any services provided to me.

Client Signature: _____

Date:_____

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CHILD HISTORY

Client name:_____ Date _____

Filled out by:_____ Relationship:_____

Racial/Ethnic Identity:_____

PRESENTING PROBLEMS

Presenting problems **Duration** (months)

_____ _____

EMOTIONAL/PSYCHIATRIC HISTORY

[ ] [ ] Prior psychotherapy?
No Yes If yes
Prior provider name Address Phone

_____ _____ _____

Beneficial?_____ How Long?_____

[ ] [ ] Prior or current psychotropic medication usage?

No Yes if yes please describe

Medication	Dosage	Start date	End date	Physician	beneficial?

List name of psychiatrist: (if any):

Name _____ Phone_____

[ ] [ ] History of Trauma?
No Yes If yes, please describe

_____

_____

[ ] [ ] Has any family member had any mental health treatment or diagnosis No Yes If yes, who/what (list all):

_____

_____

Please indicate siblings gender and ages

_____

_____

Describe any custody arrangements and people in other households

_____

_____

DEVELOPMENTAL HISTORY (check all that apply for a child/adolescent patient)

Problems during mother's pregnancy:

[ ] none
[ ] cigarette use
[ ] high blood pressure
[ ] kidney infection
[ ] German measles
[ ] emotional stress
[ ] bleeding
[ ] alcohol use
[ ] drug use

Birth:

[ ] normal delivery
[ ] difficult delivery
[ ] cesarean delivery
[ ] complications _____
_____
birth weight ____lbs ____oz.

Infancy:

[ ] feeding problems
[ ] sleep problems
[ ] toilet training problems

Childhood health:

[ ] chickenpox (age _____)
[ ] German measles (age _____)
[ ] red measles (age _____)
[ ] rheumatic fever (age _____)
[ ] whooping cough (age _____)
[ ] scarlet fever (age _____)
[ ] autism
[ ] ear infections
[ ] allergies to _____
[ ] significant injuries _____
[ ] chronic, serious health problems _____
[ ] lead poising (age _____)
[ ] mumps (age _____)
[ ] diphtheria (age _____)
[ ] poliomyelitis (age _____)
[ ] pneumonia (age _____)
[ ] tuberculosis (age _____)
[ ] mental retardation
[ ] asthma

Delayed developmental milestones (check only those milestones that did not occur at expected age):

[ ] sitting
[ ] rolling over
[ ] standing
[ ] walking
[ ] feeding self
[ ] speaking words
[ ] speaking sentences
[ ] controlling bladder
[ ] controlling bowels
[ ] sleeping alone
[ ] dressing self
[ ] engaging peers
[ ] tolerating separation
[ ] playing cooperatively
[ ] riding tricycle
[ ] riding bicycle

Emotional / behavior problems (check all that apply):

[ ] drug use
[ ] alcohol abuse
[ ] chronic lying
[ ] stealing
[ ] violent temper
[ ] fire-setting
[ ] hyperactive
[ ] animal cruelty
[ ] assaults others
[ ] disobedient
[ ] repeats words of others
[ ] not trustworthy
[ ] hostile/angry mood
[ ] indecisive
[ ] immature
[ ] bizarre behavior
[ ] self-injurious threats
[ ] frequently tearful
[ ] frequently daydreams
[ ] lack of attachment
[ ] distrustful
[ ] extreme worrier
[ ] self-injurious acts
[ ] impulsive
[ ] easily distracted
[ ] poor concentration
[ ] often sad
[ ] breaks things

Social interaction (check all that apply):

[ ] normal social interaction
[ ] isolates self
[ ] associates with acting-out peers
[ ] alienates self
[ ] inappropriate sex play
[ ] dominates others
[ ] other _____

Intellectual / academic functioning (check all that apply):

[ ] normal intelligence
[ ] high intelligence
[ ] learning problems
[ ] authority conflicts
[ ] attention problems
[ ] underachieving

Current or highest education level _____
Name of school?_____

Describe any other developmental problems or issues:

_____

_____

MEDICAL HISTORY

Describe current physical health: [ ] Good [ ] Fair [ ] Poor

Please indicate any health conditions/concerns:_____

_____

List any medications currently being taken (give dosage & reason):

_____

_____

Substances used:
(complete all that apply)

[ ] father [ ] stepparent/live-in
[ ] mother [ ] uncle(s)/aunt(s)
[ ] grandparent(s) [ ] spouse/significant other
[ ] sibling(s) [ ] children
[ ] other _____

Social support system:
[ ] supportive network
[ ] few friends

Current Use for child

	First use age	Last use age	(Yes/No)	Frequency Amount
[ ] alcohol				
[ ] amphetamines/speed				
[ ] barbiturates/owners				
[ ] caffeine				
[ ] cocaine				
[ ] crack cocaine				
[ ] hallucinogens (e.g., LSD)				
[ ] inhalants (e.g., glue, gas)				
[ ] marijuana or hashish				
[ ] nicotine/cigarettes				
[ ] PCP				
[ ] prescription_____				
[ ] other_____				

Is there anything else I should know about your child?

_____

_____

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HIPAA NOTICE OF PRIVACY PRACTICES

I. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

II. IT IS MY LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI).
By law I am required to insure that your PHI is kept private. The PHI constitutes information created or noted by me that can be used to identify you. It contains data about your past, present, or future health or condition, the provision of health care services to you, or the payment for such health care. I am required to provide you with this Notice about my privacy procedures. This Notice must explain when, why, and how I would use and/or disclose your PHI. Use of PHI means when I share, apply, utilize, examine, or analyze information within my practice; PHI is disclosed when I release, transfer, give, or otherwise reveal it to a third party outside my practice. With some exceptions, I may not use or disclose more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made; however, I am always legally required to follow the privacy practices described in this Notice. Please note that I reserve the right to change the terms of this Notice and my privacy policies at any time as permitted by law. Any changes will apply to PHI already on file with me. Before I make any important changes to my policies, I will immediately change this Notice and post a new copy of it in my office and on my website. You may also request a copy of this Notice from me, or you can view a copy of it in my office or on my website, which is located at www.cathyhanville.com.

III. HOW I WILL USE AND DISCLOSE YOUR PHI.
I will use and disclose your PHI for many different reasons. Some of the uses or disclosures will require your prior written authorization; others, however, will not. Below you will find the different categories of my uses and disclosures, with some examples.

6. Uses and Disclosures Related to Treatment, Payment, or Health Care Operations Do Not Require Your Prior Written Consent. I may use and

disclose your PHI without your consent for the following reasons:

1. For treatment. I can use your PHI within my practice to provide you with mental health treatment, including discussing or sharing your PHI with my trainees and interns. I may disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are otherwise involved in your care. Example: If a psychiatrist is treating you, I may disclose your PHI to her/him in order to coordinate your care.
2. For health care operations. I may disclose your PHI to facilitate the efficient and correct operation of my practice. Examples: Quality control - I might use your PHI in the evaluation of the quality of health care services that you have received or to evaluate the performance of the health care professionals who provided you with these services. I may also provide your PHI to my attorneys, accountants, consultants, and others to make sure that I am in compliance with applicable laws.
3. To obtain payment for treatment. I may use and disclose your PHI to bill and collect payment for the treatment and services I provided you. Example: I might send your PHI to your insurance company or health plan in order to get payment for the health care services that I have provided to you. I could also provide your PHI to business associates, such as billing companies, claims processing companies, and others that process health care claims for my office.
4. Other disclosures. Examples: Your consent isn't required if you need emergency treatment provided that I attempt to get your consent after treatment is rendered. In the event that I try to get your consent but you are unable to communicate with me (for example, if you are unconscious or in severe pain) but I think that you would consent to such treatment if you could, I may disclose your PHI.

7. Certain Other Uses and Disclosures Do Not Require Your Consent. I may use and/or disclose your PHI without your consent or authorization for the following reasons:

1. When disclosure is required by federal, state, or local law; judicial, board, or administrative proceedings; or, law enforcement. Example: I may make a disclosure to the appropriate officials when a law requires me to report information to government agencies, law enforcement personnel and/or in an administrative proceeding.
2. If disclosure is compelled by a party to a proceeding before a court of an administrative agency pursuant to its lawful authority.
3. If disclosure is required by a search warrant lawfully issued to a governmental law enforcement agency.
4. If disclosure is compelled by the patient or the patient’s representative pursuant to California Health and Safety Codes or to

corresponding federal statutes of regulations, such as the Privacy Rule that requires this Notice.

5. To avoid harm. I may provide PHI to law enforcement personnel or persons able to prevent or mitigate a serious threat to the health or safety of a person or the public (i.e., adverse reaction to meds).
6. If disclosure is compelled or permitted by the fact that you are in such mental or emotional condition as to be dangerous to yourself or the person or property of others, and if I determine that disclosure is necessary to prevent the threatened danger.
7. If disclosure is mandated by the California Child Abuse and Neglect Reporting law. For example, if I have a reasonable suspicion of child abuse or neglect.
8. If disclosure is mandated by the California Elder/Dependent Adult Abuse Reporting law. For example, if I have a reasonable suspicion of elder abuse or dependent adult abuse.
9. If disclosure is compelled or permitted by the fact that you tell me of a serious/imminent threat of physical violence by you against a reasonably identifiable victim or victims.
10. For public health activities. Example: In the event of your death, if a disclosure is permitted or compelled, I may need to give the county coroner information about you.
11. For health oversight activities. Example: I may be required to provide information to assist the government in the course of an investigation or inspection of a health care organization or provider.
12. For specific government functions. Examples: I may disclose PHI of military personnel and veterans under certain circumstances. Also, I may disclose PHI in the interests of national security, such as protecting the President of the United States or assisting with intelligence operations.
13. For research purposes. In certain circumstances, I may provide PHI in order to conduct medical research.
14. For Workers' Compensation purposes. I may provide PHI in order to comply with Workers' Compensation laws.
15. Appointment reminders and health related benefits or services. Examples: I may use PHI to provide appointment reminders. I may use PHI to give you information about alternative treatment options, or other health care services or benefits I offer.
16. If an arbitrator or arbitration panel compels disclosure, when arbitration is lawfully requested by either party, pursuant to subpoena duces tectum (e.g., a subpoena for mental health records) or any other provision authorizing disclosure in a proceeding before an arbitrator or arbitration panel.
17. If disclosure is required or permitted to a health oversight agency for oversight activities authorized by law. Example: When compelled by U.S. Secretary of Health and Human Services to investigate or assess my compliance with HIPAA regulations.

18. If disclosure is otherwise specifically required by law.Certain Uses and Disclosures Require You to Have the Opportunity to Object.
19. Disclosures to family, friends, or others. I may provide your PHI to a family member, friend, or other individual who you indicate is involved in your care or responsible for the payment for your health care, unless you object in whole or in part. Retroactive consent may be obtained in emergency situations.

8. Other Uses and Disclosures Require Your Prior Written Authorization. In any other situation not described in Sections IIIA, IIIB, and IIIC above, I will request your written authorization before using or disclosing any of your PHI. Even if you have signed an authorization to disclose your PHI, you may later revoke that authorization, in writing, to stop any future uses and disclosures (assuming that I haven't taken any action subsequent to the original authorization) of your PHI by me.

IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI
These are your rights with respect to your PHI:

A.) The Right to See and Get Copies of Your PHI. In general, you have the right to see your PHI that is in my possession, or to get copies of it; however, you must request it in writing. If I do not have your PHI, but I know who does, I will advise you how you can get it. You will receive a response from me within 30 days of my receiving your written request. Under certain circumstances, I may feel I must deny your request, but if I do, I will give you, in writing, the reasons for the denial. I will also explain your right to have my denial reviewed.

If you ask for copies of your PHI, I will charge you not more than $.25 per page. I may see fit to provide you with a summary or explanation of the PHI, but only if you agree to it, as well as to the cost, in advance.

B.) The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask that I limit how I use and disclose your PHI. While I will consider your request, I am not legally bound to agree. If I do agree to your request, I will put those limits in writing and abide by them except in emergency situations. You do not have the right to limit the uses and disclosures that I am legally required or permitted to make.

C.) The Right to Choose How I Send Your PHI to You. It is your right to ask that your PHI be sent to you at an alternate address (for example, sending information to your work address rather than your home address) or by an alternate method (for example, via email instead of by regular mail). I am obliged to agree to your request providing that I can give you the PHI, in the format you requested, without undue inconvenience. I may not require an explanation from you as to the basis

of your request as a condition of providing communications on a confidential basis.

D.) The Right to Get a List of the Disclosures I Have Made. You are entitled to a list of disclosures of your PHI that I have made. The list will not include uses or disclosures to which you have already consented, i.e., those for treatment, payment, or health care operations, sent directly to you, or to your family; neither will the list include disclosures made for national security purposes, to corrections or law enforcement personnel, or disclosures made before April 15, 2003. After April 15, 2003, disclosure records will be held for six years.

I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I give you will include disclosures made in the previous six years (the first six year period being 2003-2009) unless you indicate a shorter period. The list will include the date of the disclosure, to whom PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. I will provide the list to you at no cost, unless you make more than one request in the same year, in which case I will charge you a reasonable sum based on a set fee for each additional request.

E.) The Right to Amend Your PHI. If you believe that there is some error in your PHI or that important information has been omitted, it is your right to request that I correct the existing information or add the missing information. Your request and the reason for the request must be made in writing. You will receive a response within 60 days of my receipt of your request. I may deny your request, in writing, if I find that: the PHI is (a) correct and complete, (b) forbidden to be disclosed, (c) not part of my records, or (d) written by someone other than me. My denial must be in writing and must state the reasons for the denial. It must also explain your right to file a written statement objecting to the denial. If you do not file a written objection, you still have the right to ask that your request and my denial be attached to any future disclosures of your PHI. If I approve your request, I will make the change(s) to your PHI. Additionally, I will tell you that the changes have been made, and I will advise all others who need to know about the change(s) to your PHI.

F.) The Right to Get This Notice by Email You have the right to get this notice by email. You have the right to request a paper copy of it, as well.

V. HOW TO COMPLAIN ABOUT MY PRIVACY PRACTICES

If, in your opinion, I may have violated your privacy rights, or if you object to a decision I made about access to your PHI, you are entitled to file a complaint with the person listed in Section VI below. You may also send a written complaint to the Secretary of the Department of Health and Human Services at

200 Independence Avenue S.W. Washington, D.C. 20201. If you file a complaint about my privacy practices, I will take no retaliatory action against you.

VI. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT MY PRIVACY PRACTICES

If you have any questions about this notice or any complaints about my privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact me at:

Shanna Holladay, MA, MFT
405 Kains Avenue, Ste 102
Albany, CA 94706
(415) 643-3890

VII. EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on April 14, 2003.

I acknowledge receipt of this notice

Patient Name: _____

Date:_____

Signature: _____

Shanna Holladay, MA, MFT

3323 Sacramento Street, San Francisco, CA 94118
(415) 339-1291

Authorization to Disclose Protected Health Information to Primary Care Physician

Communication between your behavioral health provider(s) and your primary care physician (PCP) is important to make sure all care is complete, comprehensive, and well-coordinated. No information will be released without your signed authorization.

Section 1. The Patient

Last Name	First Name	Middle Initial

Subscriber Number From ID Card	Insurance Company Name	Date of Birth (MM/DD/YYYY)	Phone Number

I hereby authorize the disclosure of protected health information about the individual named above
I am:

□ the individual named above (complete Section 8 below to sign this form)

□ a personal representative because the patient is a minor, incapacitated, or deceased (complete Section 9 below)

Section 2. Who Will Be Disclosing Information About the Individual?

The following behavioral health provider may disclose the information:

Shanna Holladay, MA, MFT 3323 Sacramento Street, San Francisco, CA 94118	415-339-1291

Section 3. Who Will Be Receiving Information About the Individual?

Primary Care Doctor Information

Name	Phone Number

Section 4. What Information About the Individual Will Be Disclosed?

My general physical and mental health information , including diagnosis, treatment plan, prognosis, and medication(s) if necessary will be shared if I sign this form. And IF my records have drug and/or alcohol or HIV related information, I agree to share that information as shown below:

□ Drug and alcohol information – IF my records have drug and alcohol information, I agree to share it with the providers in Part 2.

- □ Yes, all drug/alcohol information
- □ No

□ HIV/AIDS Information - IF my records have HIV/AIDS information, I agree to share it with the providers in Part 2 of this form.

- □ Yes
- □ No

Section 5. The Purpose of the Disclosure

To release behavioral health evaluation and/or treatment information to the PCP to ensure quality and coordination of care.

This authorization shall expire 1 year from the date of signature below unless revoked prior to that date.

Section 7. Important Rights and Other Required Statements You Should Know

You can revoke this authorization at any time by writing to the behavioral health provider named above. If you revoke this authorization, it will not apply to information that has already been used or disclosed. The information disclosed based on this authorization may be re-disclosed by the recipient and may no longer be protected by federal or state privacy laws. Not all persons or entities have to follow these laws.

You do not need to sign this form in order to obtain enrollment, eligibility, payment, or treatment for services. This authorization is completely voluntary, and you do not have to agree to authorize any use or disclosure. You have a right to a copy of this authorization once you have signed it. Please keep a copy for your records, or you may ask for a copy at any time by contacting your behavioral health provider named above.

Section 8. Signature of the Individual

Signature_____Date_____

Section 9. Signature of Personal Representative (if applicable)

Signature_____Date_____

Relationship to the individual (required):

_____