AUTHORIZATION TO DISCLOSE HEALTHCARE INFORMATION

Instructions: Fill in the appropriate information in each applicable section. Incomplete forms will be returned to you unprocessed. A separate authorization must be completed for each request.

Patient Full Name: _____ Date of Birth: _____ Phone Number: _____

Address: _____ Email: _____

This authorization covers treatment dates beginning: _____

I hereby authorize:	**√ release information to:**
NAME: CHARLES GOLDBERG LPC, NCC, CAADC	**NAME:**
ADDRESS: 3005 BRODHEAD ROAD	**ADDRESS:**
BETHLEHEM, PA 18020	
PHONE: 224-430-3659	**PHONE:** **FAX:**

By signing below, I hereby authorize Charles Goldberg LPC, NCC, CAADC to disclose information contained in the medical and financial record of the patient identified above, which includes information that may be stored in a paper and/or other electronic format. Disclosure shall be limited to the following specific information contained in my records and/or obtained during the course of my diagnosis and treatment.

The following information is requested: _____

_____

The Purpose or Need for Disclosure is:

__To Transfer Client Care
__To Aid in Treatment
__Application for Provider Coverage
__Applying for Insurance
__For Discharge Planning
__Psychological Report
__To Inform Family
__To Update Medical Records
__To Aid in financial account activity
__Referral Source
__Employer
__Other (specify) _____
__Legal/Court System
__Disability Determination
_____

Disclosure Format (Paper/US Mail or Fax is default if not marked.): Specify ¨E-mail" or other Electronic format¨: **All forms**

This authorization will expire at the time of disclosure of requested information or on _____ (date cannot be more than 180 days after date signed below).

- I may revoke this authorization at any time. Revocations to this authorization may be requested verbally or in writing to any facility staff person
- I understand that Charles Goldberg LPC, NCC, CAADC will not condition my treatment, payment, enrollment or eligibility for benefits on whether I provide this authorization. I have provided my voluntary consent to allow the sharing of protected health information.

By signing below I acknowledge that I am aware of the confidential and/or privileged nature of the information being disclosed, and understand the benefits and/or disadvantage of disclosing such information.

_____ _____ _____

Patient Signature | Print Name | Date

_____ _____

Signature of Witness | Date

Notice to Recipient: This authorization provides for a ·release of information about an individual whose confidentiality is protected by federal and state laws and regulation, including the Health Insurance Portability and Accountability Act of 1996 (45 C.F.R. §160-164) as well as 42 C.F.R part 2 and 42 U.S.C. §. §290dd-2, and state confidentiality laws. Information regarding substance abuse treatment disclosed from this authorization may not be re-disclosed without the specific written consent of the individual about whom such information pertains.

Patient was offered a copy of this consent and it was: ☐ Received ☐ Declined **X**_____

Created 8/18/19