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AUTHORIZATION FOR RELEASE OF INFORMATION

I, the undersigned, hereby authorize **Lindsey Burns, LPC/Kaleidoscope Wellness PLLC** to disclose my Private Health Information to the below named entity.

LIST THE NAME, PHONE, ADDRESS, AND EMAIL OF THE SOURCE TO/FROM WHICH INFORMATION IS TO BE RELEASED:

❑ Mental Health Records
❑ Court/Legal Records
❑ Psychiatric Evaluations
❑ Progress Notes
❑ Treatment plans, recovery plans, aftercare plans
❑ Intake Assessment/ Biopsychosocial Assessment
❑ Discharge summaries
❑ Psychosocial histories, assessments with diagnoses, prognoses recommendations, and all similar documents.

❑ Information about how the patient's condition affects or has affected ability to complete tasks, activities of daily living, or ability to work.
❑ Test Results
❑ Report of Teachers' observations
❑ Achievement and other test results.
❑ Consultations
❑ AIDS/HIV Related Information
❑ Substance abuse (drug/alcohol) Records
❑ Medical Records (excluding HIV-related information)
❑ Communicable Disease Information
❑ Crisis Assessments/ Interventions

❑ Entire Chart

D. Select Only One:

❑ Please forward the records to the address at the top of this form.
❑ Please forward the records to the address written above.

I understand that: (a) I may keep a copy of this form after I sign it, and/or I may request a copy from the named clinician; (b) treatment, payment, enrollment, or eligibility for benefits is not conditioned on my signing this authorization; (c) the information used or disclosed under this authorization to another party may be subject to release by that party and is no longer the responsibility of the named clinician and may not be protected by federal privacy regulations; and (d) I may revoke this authorization at any time by notifying the named clinician in writing, as described below. This will not affect any action the named clinician took prior to receiving the revocation.

I understand that this authorization will expire on the earlier of (a) twelve months from the date of signature, (b) completion of the recommended treatment and all related payment activities, or (c) by the date the undersigned sets here: _____

_____ _____
Signature of Client or Legal Representative Date

_____ _____
Printed Name Relationship to Patient

To The Recipient of This Release of Information:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosures of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of other medical or other information is not sufficient for this purpose. The Federal rules restrict any use of this information to criminally investigate or prosecute any alcohol or drug patient.

Arizona Revised Statutes (ARS 36-561) prohibit recipients from secondary disclosure/release of information related to HIV Communicable Diseases, to additional persons/organizations without the specific written consent of the client/guardian.