Matt Case, LCMHC
1829 E. Franklin St., Suite 1200C, Chapel Hill, NC, 27514

AUTHORIZATION FOR THE RELEASE AND RECIPEROCAL EXCHANGE OF PROTECTED HEALTH INFORMATION

_____ _____
Client Name Date of Birth

This form, when completed and signed by you, allows the exchange of protected health information between Matt Case, LPC and the person or agency you designate below. This authorization is not a blanket wavier: it allows for specific information to be shared with specific people for a specific purpose, as indicated by you below.

The purpose of this disclosure is:
__ To assist with treatment __ To make a referral __ To allow for billing
__ Other: _____

I am authorizing Matt Case, LCMHC and the person or agency below to share protected health information about me or my child:

Person/Agency _____
Address _____
City/State/Zip _____
Phone: _____ Fax _____

I am authorizing only the following information to be released:

Client Initials	Information
____	Psychological and/or psychiatric evaluation and diagnosis
____	Clinician or case manager treatment plan and/or service notes
____	Medication information
____	Verbal exchange regarding client evaluation and treatment
____	Intake and Discharge Summaries
____	School attendance record
____	School conduct information
____	Education achievement information
____	Verbal exchange with school personnel regarding client evaluation, treatment
____	Financial information required for reimbursement
____	Other: _____

This authorization will remain in effect until _____.
I may revoke this authorization at any time by giving written notice.

This authorization is fully understood and is voluntarily made on my part.

_____ or _____
Patient's Signature *Parent or legally appointed representative's signature*

_____ _____
Date of signature *Relationship*

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.