www.subrosamentalservices.com
84-757 Kiana Place, Waianae, HI 96792
808-452-2515

Standard Authorization For Disclosure Of Mental Health Treatment Information

I, _____, whose Date of Birth is _____, authorize

Sub Rosa Mental Services to disclose to and/or obtain from:

_____ the following information
(Who Are we releasing information to)

Description of Information to be Disclosed (Patient/Client should initial each item to be disclosed)

_____ ADA Anti-Discrimination Law results from PSD Forensic Evaluation
_____ Assessment
_____ Current Treatment Update
_____ Diagnosis
_____ FHA Anti-Discrimination Law results from ESA Forensic Evaluation
_____ Medication Management Information
_____ Presence/Participation in Treatment
_____ Psychiatric Evaluation
_____ Psychological Evaluation
_____ Psychosocial Evaluation
_____ Treatment Plan or Summary
_____ OTHER Please specify _____

Purpose
_____ Educational Information
_____ Discharge/Transfer Summary
_____ Continuing Care Plan
_____ Progress in Treatment
_____Psychotherapy Notes*
(*Cannot be combined with any other disclosure)

_____ OTHER Please specify _____

This information may be used or disclosed in connection with mental health treatment, payment, or healthcare operations.

Revocation:

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Sub Rosa Mental Services at administration @subrosamentalservices.com I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration

Unless sooner revoked, this authorization expires 90 days from signature: or as otherwise indicated:_____

Conditions

I further understand that Sub Rosa Mental Services will not condition my treatment on whether I give authorization for the requested disclosure.

However, it has been explained to me that failure to sign this authorization may have the following consequences:

____Not providing results as requested can limit services patient is requesting.

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Redisclosure

I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections.

If requested I will be given a copy of this authorization for my records.

_____

Signature of Patient/Client Date

_____

Signature of Parent, Guardian or Personal Representative Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.).