Steve Tobin

Licensed Clinical Social Worker
Licensed Addiction Counselor
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Authorization Form

This form, when completed and signed by you, authorizes the release or exchange of protected information from your clinical record.

I authorize the mutual exchange of protected information between Steve Tobin LCSW, LAC and the following party:

Name:_____
Address: _____

(Provide description of the information that you want shared or disclosed. Your description should be as specific and detailed as possible.)
_____
_____

I am authorizing the mutual exchange of this information for the following reasons: _____
_____
_____

This Authorization shall remain in effect until (fill in expiration date) or until (fill in an event that relates to the individual or the purpose of the use or disclosure): _____
However, I understand that this Authorization does not permit disclosure of my future health care given more than 6 months from the date of this Authorization (unless this is for disclosures to insurance companies); and shall be effective not more than 30 months from the date of this Authorization. If this Authorization does not contain an expiration date, the Authorization expires 6 months from the date of my signature.

I understand that I have the right to revoke this authorization at any time, unless Steve Tobin LCSW, LAC has taken substantial action in reliance on the authorization.

I understand that Steve Tobin LCSW, LAC generally may not condition services upon my signing an authorization unless the services are provided to me for the purpose of creating health information for a third party.

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. However if this disclosure consists of information about a client involved in chemical dependency services the following applies:

PROHIBITION OF REDISCLOSURE: 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 disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or has otherwise permitted by 42 CFR Part 2. A federal authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

_____ _____
Name of Patient (Please Print) Date of Birth:

_____ _____
Signature of Patient Date

Witness: _____

(If a personal representative of the patient signs the authorization, provide a description of such representative's authority to act for the patient.