CREEKSIDE
COLLABORATIVE THERAPY, PLLC

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Authorization

I hearby authorize release of my confidential mental health information as described below. I understand that this authorization is voluntary. I understand that if the organization/person authorized to receive the information is not a health care provider, a mental health care provider, or a health plan, the released information my no longer be protected by the federal privacy regulations

1. **Name (first and last name):**

   _____

2. **Date of Birth:**

   _____

3. **This authorization allows Creekside Collaborative Therapy to receive and provide information to/from _____ for the purpose of continuity and coordination of care.**

   _____

   _____

   _____

   _____

4. **This release of information will be used solely for the purpose of treatment planning and coordination of care unless specifically noted as follows:**

   _____

5. **This authorization is valid for (choose one):**

   ○ One year

   ○ Through the duration of mental health treatment at Creekside (not to exceed two years)

   ○ Other chosen duration (please indicate duration in text box below; may not exceed two years)

   Other chosen duration (if applicable):

   _____

6. **I understand that I may revoke this authorization at an time in writing, except as to information released before the recipt of this revocation.**

   ☐ yes ☐ no

7. **I understand that my mental health care will not be denied if I refuse to sign this authorization.**

   ☐ yes ☐ no

8. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer subject to privacy protections.

☐ yes ☐ no

9. I understand that I am entitled to a copy of this authorization and may print this form if I desire a copy.

☐ yes ☐ no

_____ _____

Signature Date