Emilia Fulop, LMHC
Authorization of Release of Information

By completing this release, you are authorizing the disclosure and/or use of your protected, personal information as described below, consistent with state and federal laws concerning privacy of such information. If you do not fully complete this form with all information requested, this authorization is invalid. Release can be rescinded at any time by completing an official written request signed by the party authorizing this release.

I, _____whose Date of Birth is _____, authorize Emilia Fulop, LMHC to (check one or both of the following):

- ☐ Disclose information to and/or
- ☐ Obtain information from:

Name: _____

Relationship: _____

Contact:_____

INFORMATION MAY BE USE OR DISCLOSED THROUGH AUTHORIZATION

- ☐ Clinical History from dates: _____
- ☐ Admission/discharge reports
- ☐ Psychological reports, evaluation & testing results:
- ☐ Treatment plans or summary
- ☐ Psychiatric records
- ☐ Other, please specify: _____

PURPOSE OF RELEASE OF INFORMATION

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

- ☐ Coordination of Care
- ☐ At request of client
- ☐ Other, please specify: _____

INFO MAY BE USED OR DISCLOSE THROUGH THIS AUTHORIZATION ADDENDUM

I specifically authorize the release of health information relating to drug and/or alcohol use. I understand that my records are protected under federal regulations governing confidentiality of alcohol and drug use patient records (42 CFR Part 2) and cannot be disclosed without my written consent unless otherwise provided for in the federal regulations. The recipient of drug and/or alcohol abuse information disclosed as a result of this authorization will need my further written authorization to disclose this information.

Signature: _____ Date: _____

I specifically authorize the release of information relating to AIDS or HIV.

Signature: _____ Date: _____

RIGHTS & OTHER INFORMATION: READ & INITIAL YOUR CONSENT

1.) I understand that I have a right to revoke this authorization at any time by sending written notification to Emilia Fulop, LMHC at efuloplmhc@gmail.com. I further understand that a revocation of the authorization is not effective to the extent that information has been shared based upon this dated authorization. **INITIAL HERE**: _____

2.) I understand that I may refuse to sign this release and that my refusal to sign will not affect my ability to obtain treatment, but acknowledge that Emilia Fulop, as a mandated reported, still is required by law to disclose information in consultation or to the authorities if there is threat of harm to self or others disclosed. **INITIAL HERE**: _____

3.) I understand that if the person or entity that receives my protected health information is not required to comply with federal privacy regulations, the information I have released may be re-disclosed and would no longer be protected by HIPAA regulations. **INITIAL HERE**: _____

4.) I will be given a copy of this authorization for my records.

5.) 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. **INITIAL HERE**: _____

Unless sooner revoked, this authorization expires on the following date: _____ or as otherwise indicated (specify here):_____

_____

SIGNATURE FOR AUTHORIZATION

I authorize this release of information by signing below.

Signature of Client: _____

Printed Name: _____

Date: _____

-continued on next page for proxy/guardian signature-

When a client is not competent to give consent, or is under the age of 18, the signature of a parent, guardian, health care agency (proxy) or other representative is required:

Signature of Legal Representative:_____

Printed Name: _____

Describe your authority to act for client: _____

Date:_____

_____ _____ _____ _____ _____ _____ _____

Signature of Clinician: _____

Print name and license: Emilia Fulop, LMHC

Date: _____