Feathergill & Associates, LLC

3625 Park Place West, Suite 150 South Bend, IN 46601 Phone: 574-282-1090

RELEASE OF INFORMATION CONSENT FORM

I, _____, authorize Feathergill and Associates, LLC to: provide confidential Patient Health Information to the following agencies or people:

_____

Name Address City State Zip Phone

_____

Name Address City State Zip Phone

_____

Name Address City State Zip Phone

( ) Academic Testing Results
( ) Behavior Programs
( ) Case Notes
( ) Intelligence Testing Results
( ) Entire Record
( ) Personality Profiles
( ) Progress Reports
( ) Psychological Reports
( ) Psychological Testing Results
( ) Service Plans
( ) Summary Reports
( ) Vocational Testing Results
( ) Other (specify) _____
_____
_____

The above information will be used for the following purposes:

( ) Planning Appropriate Treatment or Program
( ) Continuing Appropriate Treatment or Program
( ) Determining Eligibility for Benefits or Program
( ) Case Review
( ) Updating Files
( ) Other (specify) _____

I understand that I may revoke this consent at any time by providing written notice, and after one year this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information.

Signature of Client _____ Date_____

Signature of Parent/Guardian _____ Date_____

Signature of Witness _____ Date_____
(If client is unable to sign)

Signature of Person Informing _____ Date_____
Client of Rights

PATIENT RIGHTS AND HIPAA AUTHORIZATIONS
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The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time ("HIPAA").

1. Tell your counselor if you don't understand this authorization, and the counselor will explain it to you.

2. You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained, and you are in the research-related treatment program or have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a client in their practice.

3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment or payment or your eligibility for benefits. If you refuse to sign this authorization, and you are in a research-related treatment program or have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a client in their practice.

4. Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA.

5. If this office initiated this authorization, you must receive a copy of the signed authorization.

6. ***Special Instructions for completing this authorization for the use and disclosure of Psychotherapy Notes.*** HIPAA provides special protections to certain medical records known as "Psychotherapy Notes." All Psychotherapy Notes recorded on any medium (i.e., paper, electronic) by a mental health professional (such as a therapist, psychologist or psychiatrist) must be kept by the author and filed separate from the rest of the client's medical records to maintain a higher standard of protection. "Psychotherapy Notes" are defined under HIPAA as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint or family counseling session and that are separate from the rest of the individual's medical records. Excluded from the "Psychotherapy Notes" definition are the following: (a) medication prescription and monitoring, (b) counseling session start and stop times, (c) the modalities and frequencies of treatment furnished, (d) the results of clinical tests, and (e) any summary of: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

In order for a medical provider to release "Psychotherapy Notes" to a third party, the client who is the subject of the "Psychotherapy Notes" must sign this authorization to specifically allow for the release of "Psychotherapy Notes". Such authorization must be separate from an authorization to release other medical records.