BRITTANY VERA, LCSW
HARMONY PSYCHOTHERAPY, LLC

CLIENT NAME: _____

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Client name: _____ Date of birth:_____

I,_____ , hereby give my authorization for Brittany Vera, LCSW and Harmony Psychotherapy, LLC, to exchange information about me with:

Name: _____

Address: _____

Phone number: _____

This information is to be released for the purpose of: _____

_____

I authorize the individual(s) listed above to use or disclose the following information: (please check all that apply)

- ☐ Complete copy of the clinical record. *(If you do not check this, please check all parts that apply below).*
- ☐ Outpatient treatment records for psychological, psychiatric, or emotional illness.
- ☐ Outpatient treatment records for drug and/or alcohol abuse.
- ☐ Assessment and termination summaries.
- ☐ Psychological evaluation(s), reports, assessments, treatment notes, summaries, or other documents with diagnoses, prognoses, recommendations, or testing records, and behavioral observations and checklists completed by any staff member or the client, or similar documents.
- ☐ Treatment plans.
- ☐ Social, family, educational, and vocational histories.
- ☐ Progress notes.
- ☐ Evaluations and reports of consultants.
- ☐ Information about how the client's condition(s) affects or has affected her/his ability to work, and to complete tasks and activities of daily living.
- ☐ Career evaluations and reports.
- ☐ Billing records.
- ☐ Academic and educational records, including achievement and other test results, reports of teachers' observations, and all other school or special education documents.
- ☐ HIV-related information and drug and alcohol information contained in these records will be released under this authorization unless indicated here: ☐ DO NOT release these.
- ☐ Other: _____

Brittany Vera, LCSW• Harmony Psychotherapy, LLC
501 Church Street NE • Suite 208• Vienna, VA 22180• Phone/Fax: (703)592-4243

Dates of care included:
From: _____ to _____ and
From: _____ to _____ and
From: _____ to _____

Please initial each statement below:
I understand that the duration of consent shall be no longer than 6 months from the date of my signature. I understand that after that date, no more of this information can be used or released to the person or organization unless I sign a new Authorization for Release of Information form. _____

I understand that I can revoke or cancel this Authorization for Release of Information at any time by submitting a written request to the privacy officer of the organization listed above and which is to supply this information. If I do this, it will prevent any releases after the date it is received, but cannot change the fact that some information may have been sent or shared before that date. _____

I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from the professional or facility listed above, nor will it affect my eligibility for benefits. _____

I understand that I may inspect and have a copy of the health information described in this authorization. _____

I understand that this information can be redisclosed and no longer subject to the protection of the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

This release will expire on: _____, no more than six months from the date of signing.

I affirm that everything in this form that was not clear to me has been explained and I believe I now understand all of it.
Please complete all blank areas on this release prior to client's signature.
Print name: _____

Signature of client: _____ Date:__ _____

Printed name of Parent/Guardian: _____

Signature of parent or guardian (if applicable):_____

Print name of witness: _____

Signature of witness: _____ Date: _____

Request for prohibition of re-disclosure: This information has been disclosed from records for which confidentiality is protected. We request that you prohibit re-disclosure of this information unless the individual provides you with written consent.
A photocopy of this completed release is considered to be as valid as the original

Brittany Vera, LCSW• Harmony Psychotherapy, LLC
501 Church Street NE • Suite 208• Vienna, VA 22180• Phone/Fax: (703)592-4243