

Destination Greatness, PLLC

Authorization to Release Information

I, _____, whose Date of Birth is _____,

authorize **Destination Greatness, PLLC** to disclose to and/or obtain from:

_____ the following information:

Description of Information to be Disclosed

- | | |
|--|--|
| <input type="checkbox"/> Assessment | <input type="checkbox"/> Nursing/Medical Information |
| <input type="checkbox"/> Diagnosis | <input type="checkbox"/> Educational Information |
| <input type="checkbox"/> Psychosocial Evaluation | <input type="checkbox"/> Discharge/Transfer Summary |
| <input type="checkbox"/> Psychological Evaluation | <input type="checkbox"/> Continuing Care Plan |
| <input type="checkbox"/> Psychiatric Evaluation | <input type="checkbox"/> Progress in Treatment |
| <input type="checkbox"/> Treatment Plan or Summary | <input type="checkbox"/> Demographic Information |
| <input type="checkbox"/> Current Treatment Update | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Medication Management Information | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Presence/Participation in Treatment | |

Purpose

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services.

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to **Shanna A. Jefferson, Executive Director**, at 1410 W Chapel Hill St Durham, NC 27701. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration

Unless sooner revoked, this authorization expires on the following date: _____.

Conditions

I further understand that **Destination Greatness, PLLC** will not condition my treatment on whether I give authorization for the requested disclosure.

Form of Disclosure

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.

Redisclosure

I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections.

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

Signature of Patient/Client Date

Signature of Parent, Guardian or Personal Representative Date

Check here if patient/client refuses to sign authorization

Signature of Staff Witness Date