Serenity Place, LLC
22530 Washington Street, #1
Leonardtown, MD 20650
P: 301-690-8008 F: 312-260-7996

AUTHORIZATION TO DISCLOSE INFORMATION

I, ________________ ,the parent/guardian of ________________________________

(whose Date of Birth is _____________), authorize Serenity Place, LLC to disclose to and/or obtain from:

____ the following information regarding:

Description of Information to be Disclosed

(Client should initial each item to be disclosed)

_____ Assessment

_____ Diagnosis

_____ Psychosocial Evaluation

_____ Treatment Plan or Summary

_____ Current Treatment Update

_____ Presence/Participation in Treatment

_____ Educational Information

_____ Discharge/Transfer Summary

_____ Demographic Information

_____Psychotherapy Notes*

(*Cannot be combined with any other disclosure)

______Other_________________________

______Other_________________________

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 Serenity Place, LLC at the above address. 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: ________________ or as otherwise indicated:

____

Conditions

I further understand that Serenity Place will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences:

____

Form of Disclosure

Unless you have specifically requested in writing that the disclosure be made in a certain format, I reserve the right to disclose information as permitted by this authorization in any manner that I 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 Parent, Guardian or Personal Representative Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.).

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