

Serenity Place, LLC  
22530 Washington Street, #1  
P.O. Box 1831  
Leonardtown, MD 20650  
P: 301-690-8008 F: 312-260-7996

## AUTHORIZATION TO DISCLOSE INFORMATION

I, \_\_\_\_\_, 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.

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**Expiration**

Unless sooner revoked, this authorization expires on the following date: \_\_\_\_\_ or as otherwise indicated:

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**Conditions**

I further understand that Serenity Place, LLC 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:

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**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.

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Signature of Patient/Client

Date

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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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