Authorization for Use or Disclosure of Protected Health Information Client Information

Client Name: _____

DOB: _____

Release for: **Essex Pediatrics Staff**

Phone: (802) 879-6556

Address: Essex Jct., VT

In order to facilitate psychological assessment and/or treatment, I authorize, Gina Watson, LICSW, to disclose protected health information to and request protected health information from Essex Pediatrics Staff.

In addition, I authorize, Gina Watson, LICSW, to use the Electronic Health Record at Essex Pediatrics to maintain all records related to mine or my child's care. I understand that this means that all notes and assessments will be contained in the Essex Pediatrics Electronic Health Record, where they can be reviewed by Essex Pediatrics medical staff.

I understand the following:

- I may revoke this consent at any time by notifying the above named clinician ion writing, except to the extent that action has already been taken based on my previous consent. This consent will be effective unless and until I revoke it in writing.
- The information released in response to this consent may be disclosed by the recipient and may no longer be protected by federal or state law.
- I am not required to sign this consent. My treatment cannot be conditioned on the signing of this consent.

I understand that substance abuse disorder records are protected under federal law, including the federal regulations governing the confidentiality of substance use disorder patient records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

I have read this form and certify that I understand its contents.

Signature of Client: _____

Signature of parent/guardian (if client is under 18): _____

Date: _____