MaryEllen Agolia, PhD, LLC
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AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

CLIENT NAME: ____ hereby authorizes **MaryEllen Agolia, PhD** to disclose the Protected Health Information (PHI) described below to the following individual or organization:
NAME: ____
ADDRESS: ____
PHONE NUMBER: ____

- ◯ Partial Mental Health Records: Treatment Plans, Progress Notes, Appointments, and Compliance
- ◯ Complete Mental Health Records: Records, Reports, and Information Regarding Psychological Evaluations, Assessments, Treatment Plans, Progress Notes, Appointments, and Compliance
- ◯ Specific Mental Health Records: Records & Reports Regarding the History of:
  - Alcohol Use/Drug Use
  - Probation/Parole Conditions
  - Criminal & Delinquent History
  - Other: ___________________
- ◯ Educational Records: Records, Reports, and Information to Include IEP's, Grades, Attendance, Behavior, Evaluations, and Assessments
- ◯ Medical Records: Records, Reports, and Information Regarding Medical Prognosis, Medications, and Treatment (these notes do not include counseling records)
- ◯ FULL DISCLOSURE OF RECORDS AT DISCRETION OF THERAPIST
- ◯ OTHER: ____

The purpose of the disclosure(s) of PHI herein is to:

- ◯ Coordinate, Manage, and Provide Services related to: Medical/Mental Health/Educational/Criminal Justice
- ◯ Coordinate Treatment Services

I understand that my records are currently protected under the Federal privacy regulations within the Health Insurance Portability and Accountability Act (HIPAA), 45 C.F.R. , Parts 160 and 164. I further understand that the information specified above will be disclosed pursuant to this authorization, and that the recipient of the information may re-disclose the information and that it may no longer be protected by the HIPAA privacy law. To continue protection of your records and PHI with the recipient of your records be sure to ask for, review, and sign a copy of their privacy policy and discuss any concerns with the recipient.

I understand that Substance Abuse records, both alcohol and drug, have a specific protection under Part 2 of Title 42 of the Code of Federal Regulations and cannot be disclosed without my written consent.

I understand that this authorization remains in effect while I am a client of MaryEllen Agolia, PhD, LLC and automatically terminates 90 days after my last counseling session or when my account financially closed. I understand that I may revoke this authorization at any time prior to its expiration. I understand that I must revoke this authorization in writing and that I must deliver a copy to MaryEllen Agolia, PhD, LLC in person or by certified mail through the US Postal Service. I further understand that the revocation of this authorization takes effect when it is received by MaryEllen Agolia, PhD, LLC.

I understand that the entity seeking this authorization is permitted under Part 2 of Title 42 of the Code of Federal Regulations and HIPAA regulations to set the signing of this authorization as a condition of providing treatment. By refusing to sign this authorization I understand that I may not be able to continue as a client and that enrollment in a health care plan and/or eligibility for benefits and/or payment under my health insurance policy may be refused by the insurer and that I will be responsible for the full outstanding balance of my treatment.

I understand that I am entitled to receive a copy of this authorization after it is signed.

CLIENT SIGNATURE: ____ **DATE:** ____________________________
PROVIDER SIGNATURE: ____ **DATE:** ____________________________