Discovery Cove Recovery and Wellness Center, LLC
P.O. Box 771777
Eagle River, AK 99577-7718
Phone: (907) 694-5550 * Fax (907) 694-5570

Authorization to Disclose Protected Health Information

Client Name:_____DOB: _____

I hereby authorize Discovery Cove to disclose to (name and function of the person or entity to whom disclosure is to be made)_____ the following information:

____ Entire File	____ Psychotherapy Notes	____ Session Start/Stop Times
____ Diagnosis	____ Treatment Plan	____ Symptoms
____ Prognosis	____ Progress to Date	____ Clinical Test Results
____ Modalities & Frequencies of Treatment Furnished	____ Dates of Treatment	____ Educational functioning and testing
____ Other (Specify):		

I understand that I have a right to receive a copy of this authorization. I also understand that any cancellation or modification of this authorization must be in writing, and received by the provider. I understand that I have the right to revoke this authorization at any time unless Provider has taken action in reliance upon it. I understand that Provider cannot condition treatment upon me signing this authorization.

The specific uses and limitations on the types of medical information to be disclosed are as follows:

_____

Such disclosure shall be limited to the following specific types of information:

_____

This release of information is: ____ Reciprocal ____ Non-Reciprocal

This authorization / consent is valid immediately and shall remain valid until: _____(one year from date) unless otherwise revoked in writing.

I understand that the health information disclosed pursuant to this authorization may be subject to re-disclosure by Recipient and that the Federal Privacy Rule may no longer protect such information, although the re-disclosure of such information may be protected by applicable Alaska law.

I understand that the records to be released may contain information pertaining to psychiatric treatment and/or treatment for alcohol and/or drug dependence. These records may also contain confidential information about communicable diseases including HIV (AIDS) or related illness. I understand that these records are protected by the Code of Federal Regulations Title 42 Part 2 (42 CFR Part 2) which prohibits the recipient of these records from making any further disclosures to third parties without the express written consent of the patient.

I acknowledge that I have been notified of my rights pertaining to the confidentiality of my treatment information/records under 42 CFR Part 2, and I further acknowledge that I understand those rights.

_____ _____
Patient Signature Date

_____ _____ _____
Parent/Guardian Signature Parent/Guardian Name (Print) Date

_____ _____ _____
Witness Signature Witness Name (Print) Date