MLB Therapy, PLLC

Michelle Bogdan, LCSW
120 East Market Street, Unit 2; Leesburg, VA 20176
(703)554-2882; (f) (703) 443-0600

Authorization for Release of Information

Client: _____ DOB: _____

I, _____, authorize Michelle Bogdan, LCSW, to disclose and receive information with the identified person(s) below.

Name / Professional Title or Relationship to client:	Agency/Relationship:
Address:	Phone No. / Fax No.:

I agree to the following information to be shared (Please ***initial*** all agreed upon subjects below.):

_____ Demographic Information
_____ Assessment
_____ Diagnosis
_____ Psychosocial Evaluation
_____ Neuro/Psychological Evaluation
_____ Psychiatric Evaluation
_____ Treatment Plan or Summary
_____ Current Treatment Update
_____ Medication Management Information
_____ Presence/Participation in Treatment
_____Nursing/Medical Information
_____ Educational Information
_____ Discharge/Transfer Summary
_____ Progress in Treatment
_____ Continuing Care Plan
_____ Psychotherapy Notes*
(*Cannot be combined with any other disclosure)
_____ Participate in Sessions
_____ Alcohol / Drug History
_____ Attendance
_____ Financial Payment of Account
_____ 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.

If the purpose is other than marketing, sale of information, research or as specified above, please specify:
_Treatment Coordination _____
Marketing

- ☐ If the purpose of this disclosure is for marketing purposes, please check this box and set forth the financial remuneration amount received by the [Social Work Organization] in exchange for disclosing the information.$_____

Sale of Information

- ☐ If the purpose of this disclosure is for the sale, license to use or lease of the information, please check this box.

© Popovits & Robinson, P.C. 2013

Research

- ☐ If the purpose of this disclosure is for research purposes, please check this box and identify the current and future research studies as well as whether each research study is conditioned upon execution of this authorization and individual's ability to opt into each study.

  _____.

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Michelle Bogdan, LCSW at MLB Therapy, PLLC; 704 South King Street, Ste. 1; Leesburg, VA 20175. 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

This release will be effective starting the date signed below and, unless sooner revoked, will automatically expire one year from the signature date or as otherwise indicated below.

_____

Conditions

I further understand that MLB Therapy, PLLC/ Michelle Bogdan, LCSW 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, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Re-disclosure

I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be re-disclosed 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.

_____	_____	_____	_____
Client Signature	Date	Parent/Guardian Signature	Date

_____	_____
Witness Signature	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.).

_____Check here if patient/client refuses to sign authorization

I will be given a copy of this authorization for my records. Initial if copy is declined. _____

© Popovits & Robinson, P.C. 2013