Kelley Armbruster, PhD, LISW-S, FAPA, LLC
Protected Health Information Release Authorization

I, _____ [Insert Name of Client], who's Date of Birth is _____,

authorize Kelley Armbruster, PhD, LISW-S, LLC to disclose to and/or obtain from:

_____ the following information:
[Insert Name of Person or Title of Person or Organization]

Please initial checked area:

___ Assessment
___Diagnosis
___Psychosocial Evaluation
___Psychiatric Evaluation
___Treatment Plan
___Current Treatment Update
___Medication update
___ Other (Describe Below)*

___Medical Information
___Educational Information
___Discharge Plan
___Continuing Care Plan
___Summary
___Progress in Treatment
___Presence and participation

*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. (Or at the request of the client):

If other purpose, please specify: _____
_____

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Kelley Armbruster PhD, LISW-S, LLC 5720 Gateway Blvd. Suite 102, Mason, Ohio 45040. 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

Unless sooner revoked, this consent expires on the following date: _____ or as otherwise indicated: (This must be an event that relates to the individual or to the purpose or use of the disclosure)

_____

Conditions

I further understand that Kelley Armbruster, PhD, LISW-S, 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:

_____

_____

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.

Redisclosure: I understand that once this information is released that it may not have protection provided by law and may be subject to redisclosure.

I will be given a copy of this authorization for my records.

_____

Signature of Client Date

_____

Signature of Parent, Guardian or Personal Representative Date

_____

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.).

FOR CLINICIAN ONLY:

_____Check here if client refuses to sign authorization

_____

Kelley Armbruster, PhD, LISW-S, LLC Date