PAUL FLORES, MSW LCSW

Psychotherapy, Clinical Supervision and Consultation Services

Name_____ Record # _____ DOB _____

Authorization for the Disclosure and Reciprocal Exchange of Information

I hereby authorize _____Paul Flores MSW LCSW PC___ to share the specified information in my client record with:

Telephone number:_____

Agency:_____

Address:_____

This data shall include (client/legal guardian needs to initial next to each item to be released):
Intake Assessment_____
Client Profile_____
Diagnosis_____
Progress Notes_____
Summary of Treatment_____
Discharge Summary_____
Other_____ exchange of information_____x_____

The purpose of the disclosure is for:
_X_Assist with treatment ___Referral __x_Request by client ___Other_____

I hereby acknowledge that Paul Flores, MSW LCSW has not conditioned my treatment on signing this authorization, and that I may refuse to sign this authorization if I so desire. I also recognize that I have the right to revoke this authorization except to the extent that the agency has already taken action in reliance of the consent. Once information is disclosed pursuant to this signed authorization, I understand that HIPPA privacy law (45CFR Part 164) protecting health information may not apply to the recipient of the information, and therefore, may not prohibit the recipient from disclosing it. Other laws, however, may prohibit disclosure. Upon disclosure of mental health and developmental disabilities information protected by state law (GS 122C) or substance abuse treatment information protected by federal law (42 CFR Part 2), this agency informs the recipient of the information that re-disclosure is prohibited except as permitted or required by these two laws.
If not revoked earlier, this authorization expires automatically on _____ or one year from the date it is signed, whichever is earlier.
I HAVE READ THIS INFORMATION AND UNDERSTAND THAT THERE ARE STATUTES AND REGULATIONS PROTECTING THE CONFIDENTIALITY OF THE AUTHORIZED INFORMATION. I HEARBY ACKNOWLEDGE THAT THIS AUTHORIZATION IS TRULY VOLUNTARY AND THAT I AM THE PROTECTED CLIENT OR AM AUTHORIZED TO ACT ON BEHALF OF THE CLIENT TO SIGN THIS DOCUMENT. I FULLY AGREE WITH THE ABOVE STATED TERMS. I UNDERSTAND THAT I MAY REQUEST A COPY OF THIS AUTHORIZATION ONCE IT HAS BEEN SIGNED.

_____ and/or _____
Client Legally Responsible Person

_____ _____
Witness (not required) Relationship to Client

Date _____

*Client must sign whether a child or adult, information protected by Federal Regulation 42 CFR part 2

PHONE (336) 972-3123
E-MAIL eflores@triad.rr.com
1066 W. 4th Street, Suite 301
Winston-Salem, NC 27101