Exceptional Minds Counseling, LLC
Melinda G. Padolik, MSW, LISW-S
9200 Montgomery Rd., Bldg. H, Unit 25B
Cincinnati, Ohio 45242

Standard Authorization /Mental Health Treatment

I, _____ [Insert Name of Patient], whose Date of Birth is _____,

authorize Melinda G. Padolik, MSW, LISW-S to disclose to and/or obtain from:

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

Description of Information to be Disclosed.
(Patient/Client should initial each item to be disclosed)

_____ Assessment
_____ Diagnosis
_____ Psychosocial Evaluation
_____ 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
_____ Continuing Care Plan
_____ Progress in Treatment
_____ Demographic Information
_____Psychotherapy Notes*
(*Cannot be combined with any other disclosure)
_____Other_____
_____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.

Marketing

- o If the purpose of this disclosure is for marketing purposes, please check this box and set forth the financial remuneration amount received by Exceptional Minds Counseling, LLC in exchange for the disclosing the information. $_____

Sale of Information

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

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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 Melinda G. Padolik, MSW, LISW-S at 9200 Montgomery Road, Bldg. H, Unit 25B, Cincinnati, Ohio 45242. 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 authorization expires on the following date: _____ or as otherwise indicated: _____
_____

Conditions

I further understand that Melinda G. Padolik, MSW, LISW-S 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: _____
_____
[Insert an explanation of the consequences, if any, of not signing this authorization, which will depend on the services being provided].

Form of Disclosure

Unless you have specifically requested in writing that the disclosure be made in a certain format, I reserve the right to disclose information as permitted by this authorization in any manner that I deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

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Redisclosure

I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed 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 stricter than HIPAA and provides additional privacy protections.

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

_____

Signature of Patient/Client Date

_____

Signature of Parent, Guardian, or Personal Representative 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.

_____

Signature of Staff Witness Date