WSCS

West Shore Counseling Services 426 Century Lane, Ste. 100 Holland MI 49423 355-3000

Confidential

AUTHORIZATION/CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I, _____, authorize
(Name of Participant)

West Shore Counseling Services and _____

to verbally and/or in writing communicate with and disclose to one another the following information:

☐ My name and other personal identifying information; demographic information, bio-psychosocial assessment information, diagnostic impression, recommendations for treatment and services, drug testing results, medications, dates of participation, prognosis, master treatment plan, treatment progress, discharge planning, overall prognosis, and/or information related to procedural coding and reimbursement, account balance.

☐ Other: _____

The **purpose** of the authorized communication in this consent is:

☐ Coordination of services ☐ Consultation with legal and court personnel

☐ Consultation with spouse, partner, or other involved party ☐ Insurance billing

☐ Other _____

I understand that my records are protected under the Federal regulations governing Confidentiality Patient Records, 42 C.F.R. Part 2; the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Parts 160 & 164; and the Mental Health Code, Section 330.1748 of Public Act 258. I understand that my health information specified above will be disclosed pursuant to this authorization, and the recipient of the information may redisclose the information and it may no longer be protected by the HIPAA privacy law. The Federal regulations governing Patient Records, 42 C.F.R. Part 2, noted above, however, will continue to protect the confidentiality of information that identifies me as a patient in a program from redisclosure. I also understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it and that in any event this consent expires automatically one year following the closure of my file.

I understand that authorizing the disclosure of this health information is voluntary and that I can refuse to sign this authorization; however, my request to release information will not be fulfilled. I understand that the covered entity seeking this authorization is not conditioning treatment, payment, enrollment or eligibility for benefits on whether I sign the authorization. I understand that I am entitled to receive a copy of this authorization after it is signed.

In signing a release for WSCS to communicate regarding my case, I understand that the agency uses unsecured e-mail and facsimile sites. While unlikely, e-mail and Fax communications can be monitored and others may read the content of personal messages.

_____ _____
(Signature of Participant) (Date)

_____ _____

To the recipient: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute patient.

(Signature of Witness) (Date)

To the recipient: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute patient.