AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Chenal Family Therapy, PLC

10800 Financial Centre Parkway, Suite 290

Little Rock, AR 72211 501-781-2230

****TO BE COMPLETED IF YOU ARE GRANTING PERMISSION for Chenal Family Therapy, PLC, TO SEND INFORMATION TO ANOTHER PERSON, PROVIDER, or ENTITY:**

I, _____, authorize Chenal Family Therapy, PLC to send the following agencies or people information about _____ DOB _____ to:

Name: _____

Address: _____

City: _____ **State:** _____ **Zip:**_____ **Phone Number:** _____

☐ **Behavior program** ☐ **Case note** ☐ **Medical Records**

☐ **Personality profiles** ☐ **Service plans** ☐ **Summary reports**

☐ **Outside documentation** ☐ **Psychological reports**

Other:

_____

_____

The above information will be used for the following purposes:

_____

_____

****TO BE COMPLETED IF YOU ARE REQUESTING ANOTHER PERSON, PROVIDER OR ENTITY TO BE INVOLVED WITH YOUR TREATMENT, OR YOUR CHILD'S TREATMENT, AS APPLICABLE (please check specific actions that are allowed):**

I, (name of adult client or guardian) _____ authorize _____ , (Ph.No.) _____ of (address) _____ to participate in, give and receive information regarding, and act as representative for (client's name) _____. The aforementioned party may:

☐ request / receive records ☐ speak on my behalf to staff of CFT ☐ make / cancel appts

☐ handle any billing issues ☐ speak to my clinician(s) directly about my treatment, giving or receiving information

Other:

_____

_____

By signing this form in the presence of Chenal Family Therapy, PLC, personnel or a notary public, I acknowledge the following:

1. I understand that I may revoke this consent at any time by providing written notice to the address at the top of this form and after three years this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information.

2. I understand that released health information may include information related to mental health treatment, HIV-related treatment, substance abuse, and the physical abuse of spouse or children.

3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient in a way that cannot be controlled by Chenal Family Therapy, PLC and may no longer be protected under Federal privacy regulations.

4. My access to mental health services will not be affected if I do not sign this form.

5. I understand that my refusal to sign this authorization will not jeopardize my right to obtain present and future treatment for psychiatric disabilities, except where disclosure of the information is necessary for treatment.

6. I understand that if I request a copy, I can receive a copy of this completed form by U.S. mail.

7. I understand that a photocopy of this form is as valid as the original.

8. I understand that the following fees apply to release of records and court appearances and are my responsibility.

I. Cost for records is in accordance with standards set by the Arkansas Medical Board.

-$15 labor fee on all records

-.50 per page for first 25 pages, then .25 thereafter

- All postage related to the notes is required to be paid by requesting client

- $50 rush fee for anyone wanting in less than our standard 5-10 business days.

II. Treatment Summaries (separate from existing records): $100 per patient for creating new treatment summaries and a minimum of five hours of our current psychotherapy rate for depositions and consultations by the party ordering those things.

III. Court appearances, regardless on whether CFT staff member actually testifies: $2,000 per day/per CFT, PLC staff member.

Client/Guardian signature: _____ **Date:** _____
(hand-written, not digital)

Witnessed by: _____ **Date:** _____
(CFT staff member signature)

Notarized by: _____

County of: _____

Notary Stamp: