Debbie Ennis LICSW

P.O. Box 53, Barre, MA 01005
978-257-8062

Release of Information

___ I authorize: (name of person)_____

from/of (name of facility) _____

located at address/phone: _____

to disclose my information to Debbie Ennis, LICSW as described below.

___ I authorize *Debbie Ennis, LICSW* to disclose my information to the above named person/facility as described below.

___ I authorize this information to be faxed. (*Initials of client must appear here.* ____)

___ I do not authorize (or revoke) the release of information as described below. I understand that in an emergency situation my provider may exchange information about me to the extent allowed by law.

Client Name: _____ DOB: _____ Telephone #: _____

Information related to the consumer named above to be released for the purpose of continuity of care:

___ Discharge Summary ___ Psychiatric Consultations ___ History of Treatment
___ Psychological Report ___ Last Treatment Plan ___ Current Medications
___ Evaluation Summary ___ Dates of attendance **(For PCP most recent visit.)**
___ Other (**Any relevant information that will assist me in my treatment with this client.)**

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I authorize the following specific areas to be included in this Release. (*Initial on the line.)*

___ AIDS/HIV info. ___ Substance abuse/alcohol treatment ___ Sexually transmitted diseases

I understand I may revoke this consent at any time by notifying Debbie Ennis, LICSW *in writing.* My revocation will not affect information given *prior* to my signed revocation. If I do not revoke this consent, it will automatically expire **6 months** *from the date of my signature.* I understand that this request shall operate as a release of liability to Debbie Ennis, LICSW for the release of information authorized herein. I understand the terms of this authorization are governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA, 45 CFR Parts 160 and 164). I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by HIPAA.

_____	_____	_____	_____
Client's Signature (*If age 18 or older*)	Date	Parent/Guardian Signature (*If younger than 18.*)	Date

_____	_____
Witness Signature	Date