



Integrative Therapies LLC

97 Holmes Street
Quincy, MA 02171
617-770-1170

I, _____, whose date of birth is _____, authorize **Integrative Therapies, LLC** to disclose to and/or obtain from:

_____ the following information:

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

- | | |
|--|---|
| <input type="checkbox"/> Assessment | <input type="checkbox"/> Nursing/Medical Information |
| <input type="checkbox"/> Diagnosis | |
| <input type="checkbox"/> Psychosocial Evaluation | |
| <input type="checkbox"/> Psychological Evaluation | <input type="checkbox"/> Toxicological Reports/Drug Screens |
| <input type="checkbox"/> Psychiatric Evaluation | <input type="checkbox"/> Educational Information |
| <input type="checkbox"/> Treatment Plan or Summary | <input type="checkbox"/> Discharge/Transfer Summary |
| <input type="checkbox"/> Current Treatment Update | <input type="checkbox"/> Continuing Care Plan |
| <input type="checkbox"/> Medication Management Information | <input type="checkbox"/> Progress in Treatment |
| <input type="checkbox"/> Presence/Participation in Treatment | <input type="checkbox"/> Demographic Information |
| | <input type="checkbox"/> Other _____ |
| | <input type="checkbox"/> 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. If other purpose, please specify:

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to [Insert Name] at [Insert Contact Information]. 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 consent expires on _____ or as otherwise indicated:_____.

Conditions

I further understand that **S. Sherrad Barton LICSW, LADC I, CADAC** 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, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Redisclosure

Federal law prohibits the person or organization to whom disclosure is made from making any further disclosure of substance abuse treatment information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. Other types of information may be re-disclosed by the recipient of the information in the following circumstances:

_____.

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

Sherrad Barton LICSW, LADC I, CADAC Date