Liminal Solutions
Psychotherapy and Consulting, LLC

Authorization to Release Confidential Records and Information

❑ A previous *Authorization to Release Confidential Records and Information* form (ROI) dated ____/____/____ is revoked by this ROI form. The recipient identified in the previous ROI may be informed that the previous ROI has been revoked.

A. Identifying information about me/the client:

Name: _____Date of birth: ____/____/____

Other name(s) used/AKA: _____

Current address: _____

Address at time of treatment: _____

Current phone(s): _____

Medical Record #: _____

B. Because I believe it is in my/our best interest, I hereby authorize the following people to release and exchange my/the client's records and information:

S. Ileana Lindstrom, PhD
Liminal Solutions Psychotherapy and Consulting, LLC
818 High Street, Suite #4
Chestertown, MD 21620-1152
410-699-0093

Check one:

❑ Source

❑ Recipient

and

Person or organization:_____

Address:_____

Phone #: _____Fax #: _____Attention of: _____

Check one:

❑ Source

❑ Recipient

C. The records to be disclosed are marked by an × in the boxes below. The items *not* to be released have a line ~~drawn~~ through them. All periods of care are to be included unless page numbers and/or dates are indicated.

❑ Inpatient or outpatient treatment records for physical/medical and/or psychological, psychiatric, or emotional illness

❑ Date(s) of inpatient admission: ____/____/____ to ____/____/____

❑ Date(s) of outpatient treatment: ____/____/____ to ____/____/____

❑ Other identifying information about the service(s) rendered: _____

_____

❑ Psychological evaluation(s) or testing records, and behavioral observations or checklists completed by any staff member or by the client

❑ Treatment plans, recovery plans, aftercare plans

❑ Social, family, developmental histories

❑ Assessments with diagnoses, prognoses, and recommendations, and all similar documents

❑ Workshop reports and other vocational evaluations and reports

❑ Academic or educational records

❑ Psychiatric evaluations, reports, or treatment notes and summaries

❑ Admission and discharge summaries

❑ Information about how the patient's condition affects or has affected his or her ability to complete tasks, activities of daily living, or ability to work

❑ Billing records

❑ A letter containing dates of treatment(s) and a summary of progress

❑ Neurological Examination

❑ Verbal/Other Exchanges

❑ Other records: _____

HIV-related information and drug and alcohol information contained in these records will be released under this consent unless indicated here:

❑ Do not release HIV-related information.
❑ Do not release drug and alcohol information.

D. I authorize the transfer of these records for the following purpose(s) or uses:

❑ Further mental health evaluation, treatment, or care

❑Rehabilitation program development or services

❑ Treatment planning ❑Research ❑Qualification for services or benefits

❑ Mandated Treatment ❑To keep family members/significant other informed

❑ Responding to subpoena/court order from_____

❑ Other: _____

_____

E. I authorize the Source named in section B above to speak by telephone and/or face to face with the Recipient in section B about the reasons for my/the client's referral, any relevant history or diagnoses, and other similar information that can assist with my/the client's receiving treatment or being evaluated or referred elsewhere.

F. I understand that I have the right to control who receives information about my treatment and that I am not required to share information about my treatment. I understand the consequences if I refuse to allow this release. I may not receive services by the recipient or at the recipient organization. The cost of services I may receive may not be reimbursed to any degree and so will be entirely my responsibility. I may not be eligible for programs or services that could be beneficial to me.

❑ Other consequences have been explained to me. My consent is fully voluntary.

G. I understand that information authorized for disclosure by this form may not be re-disclosed without further authorization.

H. This request/authorization to release confidential information is being made in compliance with the terms of the Privacy Act of 1974 (Public Law 93-579) and the Freedom of Information Act of 1974 (Public Law 93-502), and pursuant to Federal Rule of Evidence 1158 (Inspection and Copying of Records upon Patient's Written Authorization). This form is to serve as both a general authorization, and a special authorization to release information under the Drug Abuse Office and Treatment Act of 1972 (Public Law 92-255), the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act Amendments of 1974 (Public Law 93-282), the Veterans Omnibus Health Care Act of 1976 (Public Law 94-581), and the Veterans Benefit and Services Act of 1988 (Public Law 100-322).

This request/authorization is also in compliance with 42 C.F.R. Part 2 (Public Law 93-282), which prohibits further disclosure without the express written consent of the person to whom it pertains, or as otherwise permitted by such regulations. It is in compliance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, Public Law 104-191, and with the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009, Public Law 111-5.

I. I understand that if the person or organization that receives this information is not a health care provider or health care insurer (or other covered entity under HIPAA), the information may no longer be protected by federal privacy regulations. It may, however, be protected under other laws and regulations. I understand that the Source of the information or records has no control of them after they have left the Source's premises.

J. I understand and agree that in no event shall the one who releases ("the releaser") my/the client's information and records be liable to me, or my heirs, executors, or assigns, for any reason arising from the releaser's disclosure or release of my records by acting in good faith and depending upon this authorization.

K. In consideration of this authorization, I hereby release the Source of the records and

information from any and all liability arising from the release of these records and information.

L. This authorization is valid for 12 months and is subject to revocation by me in writing at any time.

M. I understand that I may cancel and revoke this ROI authorization, but that doing this will not bring back the information that was released before the ROI was revoked. I can do this at any time by writing to the person or organization named in paragraph B as the Source telling them that I want the ROI revoked.

N. I agree that a photocopy of this form is acceptable, but it must be individually signed by me, the releaser, and a witness if necessary.

O. I have been informed of the risks to privacy and limitations on confidentiality of the use of facsimile (Fax) machines and electronic means of information transfer, and I accept these.

P. I understand that I have the right to inspect and receive copies of the information to be released.

❑ I have OR ❑ I have not reviewed the records to be released.

Q. I understand that the Source will not receive compensation for the disclosure of this information.

R. I will pay a reasonable fee for the copying/printing and postage or other delivery costs (if I choose these records to be sent) but will not have to pay for the retrieval of these records.

S. I have had the provisions of this form explained to me and believe that I fully understand this ROI, including the nature of the records, their contents, and the likely consequences and implications of their release or of my refusal to release them. I also understand that I have the right to receive a copy of this form upon my request.

T. Signatures:

_____ _____ __/__/__

Signature of Client Printed Name Date

_____ _____

Signature of client's legal representative (if applicable) Printed name

_____ ___/___/___

Relationship to Client Date

I witnessed that the person understood the nature of this ROI and freely gave his or her consent, but was physically unable to provide a signature.

_____ ___/___/___

Signature of Witness Printed name Date

(A second witness is needed if person is unable to give oral consent.)

U. I, a licensed psychologist, have discussed the issues above with the client and/or his or her legal representative. My observations of behavior and responses give me no reason to believe that this person is not fully competent to give informed, competent, and willing consent.

_____/___/___

Signature of Psychologist Printed name Date

❑ Copy for client or client's legal representative ❑Copy for Source of records

❑ Copy for Recipient of records