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AUTHORIZATION TO DISCLOSE/ ADVISE BASED ON SPECIFIC INFORMATION

Client # _____

Client Name _____ Date of Birth _____

I authorize _____,

To inform / exchange information with Paul J. Dousi, PhD, LMFT

****Note: Please circle inform or exchange or both****

This information will be used and/or disclosed for the following purposes:

- To enhance the services provided to me by Your Family Matters staff and consultants
- Individuals involved in your care or payment for your care Research* Other _____

(*Research for treatment purposes may be conditioned upon a client's signing of this release. An authorization for research may exceed one year as provided in 45 C.F.R § 164:508(c) (v).

I authorize the release and exchange (both releasing and obtaining) of the following protected health information:

Medical:

- Medication History/Summary
- Medical Reports

Mental Health:

- Assessment/Diagnostic Findings
- Psychiatric Evaluation:
- Psychological Evaluation
- Discharge Summary

School:

- Attendance Records
- Special. Education Records
- Academic Records

Legal:

- Child Maltreatment Reports
- Court or Probation Records
- Letters/Reports/Affidavits

Chemical Dependency:

- History/Assessment Reports
- Treatment Records

Other:

- Telephone Contact
- Specify: _____
- Specify: _____

I understand that I have a right to revoke this authorization at any time. I understand that if I stop this authorization, I must do so in writing to the Clinical Director. I understand that stopping this authorization will not apply to information that has already been released or disclosed.

Unless otherwise revoked, this authorization will expire in one year.

I understand that authorizing the release of this health information is voluntary. I can refuse to sign this authorization. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for redisclosure and the information may not be protected by federal privacy rules.

Signature of the Parent/Guardian/Client

Date Signed

Address

Phone Number

Relationship to Client Mother Father Client - Other: _____