O'Connell Case, LCSW, LLC

Phone: (812) 518-0380

E-Mail: oconnell@oconnellcase.com

Mailing Address
3513 E. Saddlebrook Ct.
Bloomington, IN 47401

Practice Location
2501 E. Third Street
Bloomington, IN47401

Authorization for PHI Use/Disclosure

Client Name: ________________________________ Date of Birth: ______________ Case Record No.: _____

Client Address: ____

By signing below, I hereby authorize the use or disclosure of the above-named Client's individually identifiable and protected health information ("PHI") to and/or by O'Connell Case, LCSW, LLC (OCC) for the specific purpose(s) stated below [which do not relate to the day-to-day functions performed with regard to my Treatment, Payment and certain Health Care Operations and are not otherwise required or permitted by law].

Authorization is given to:

[ ] Release information from O'Connell Case, LCSW, LLC [ ] Release information to O'Connell Case, LCSW, LLC
[ ] Release and request information to and from O'Connell Case, LCSW, LLC

Person/Entity to Release to/from or Exchange with:

Person/Entity: ____
Address: ____
City/State/Zip: ____

Instructions: Patient to "X," Date, and Initial All Applicable Sections Before Signing.

1. The Type and amount of my PHI to be used or disclosed by the Practice is as follows, subject to any content or time limits listed below:
   __ Entire Client Record (or specify below)
   __ Medical History __ Treating/Consulting Physician Reports __ Most Recent Discharge Summary
   __ Treatment Plan __ Psychosocial Assessment __ Educational Records
   __ Billing Information __ Other ____

2. State the particular purpose(s) and any client-imposed limitation(s) or expiration date, event or condition(s) or "none" here: ____

3. Indicate Specific Information (Special PHI) to be **EXCLUDED** from this authorization, if any (check all that apply):
   [ ] Drug and Alcohol Records [ ] Mental Health Records [ ] Infectious Disease Records [ ] Genetic Testing Records
4. I understand that if I do not specify an expiration date, event or condition in (2) above, this Authorization will expire in one hundred and eighty (180) days) from the date this Authorization is signed **or otherwise noted below:**
   __ Authorization is valid as long as I am in treatment with O'Connell Case, LCSW, LLC
   __ Other expiration date (Date this release will expire): __________ ________ **(Initials)**

5. I understand that the PHI used or disclosed may be subject to redisclosure by the Person/Entity receiving it. I understand that my signature on this Authorization is voluntary and my refusal to sign will not affect my ability to receive treatment from the Practice. I understand that I have a right to revoke this Authorization at any time, in a letter addressed to O'Connell Case, LCSW, LLC at the above-listed address, but the revocation will not apply (1) to PHI that has already been released in reliance on this Authorization, or (2) to PHI created by O'Connell Case, LCSW, LLC expressly for disclosure to the above-listed Person/Entity. I understand that if I have any questions regarding the use/disclosure of my PHI, I can contact O'Connell Case, LCSW, LLC at any time. _____ **(Initials)**

Signature of Client or Client's representative: ________________________________ Date: ______________

Print name of client representative: ____________________________ Relationship to client: ______________

Witness: ____ Date: ________________