Martha R. Durham, PhD, LLC (SC#981)
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AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED INFORMATION

This authorization form implements the requirements for client authorization to use and disclose health information protected by the federal health privacy law; the federal drug and alcohol confidentiality law; and state confidentiality law governing mental health, developmental disabilities, and substance abuse services.

Client's Name	Record ID	DOB:

I, _____, request and authorize **Martha R. Durham, PhD, LLC** to use or disclose to _____ the following protected information:

- Record of Individual Therapy Sessions (CPT codes 90801 and 90806)
- Diagnoses, Test Results
- Treatment Plan and Compliance

PURPOSE OF USE & DISCLOSURE

The purpose of the disclosure is to:
- document diagnoses, treatment plans and progress toward therapy goals

REDISCLOSURE

Once information is disclosed pursuant to this signed authorization, I understand that the federal privacy law (45 C.F.R. Part 164) protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from redisclosing it. Other laws, however, may prohibit redisclosure. When we disclose mental health and developmental disabilities information protected by federal law (42 C.F.R. Part 2), we must inform the recipient of the information that redisclosure is prohibited except as permitted or required by these two laws. Our Notice of Privacy Practices describes the circumstances where disclosure is permitted or required by these laws.

REVOCATION AND EXPIRATION

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it (or unless this authorization is given as a condition of obtaining insurance coverage and the insurer has a legal right to contest the policy or a claim under the policy). In any event, if not revoked earlier, this authorization expires automatically upon the date designated below by the client or one year from the date it is signed, whichever is earlier.

NOTICE OF VOLUNTARINESS

I understand that I may refuse to sign this authorization form. I understand that **Martha R. Durham, PhD, LLC** will not condition the client's treatment (or any payment, enrollment in a health plan, or eligibility for benefits) on receiving my signature on this Authorization.

SIGNATURES

Please print name: _____ Date: _____

Signature of Client: _____ Date: _____
(or guardian)

Signature of Witness: _____ Date: _____