Empowered Wellness Counseling, LLC

Authorization for Emergency Contact

Client Name: _____ Birth Date: _____

I hereby authorize _____ to:

_____ Discuss With _____ Send To _____ Receive Information From

_____
(Name and Phone Number)

For the specific purpose of:
Communication in case of an emergency, in circumstances in which I am unable to make rational decisions for my own well-being, in cases in which I am unable to be reached after three attempts by therapist, or communication as requested by me in order to help my treatment progress.

Information to be released:

____ Progress Notes
____ Treatment Plans
____ Insurance Records
____ Treatment History
____ Discharge Summary
____ Information pertaining to a specific emergency or circumstance
____ Other _____

This authorization will remain in effect for one year following the date of signature. I understand that I have the right to revoke this authorization at any time, but if I do choose to revoke I must do so in writing. I understand that the revocation will not apply to: information that has already been released in response to this authorization or my insurance company (if applicable) when law provides my insurer with right to contest a claim under my policy. I understand that authorizing disclosure of this health information is voluntary and I can refuse to sign. I need not sign in order to assure treatment. I understand that I may inspect/ copy information to be used or disclosed, as provided in HIPAA 45 CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and information may not be protected by federal confidentiality rules.

_____ _____
Signature of Client Date

_____ _____
Therapist Date