Empowering Parents, Inc.
Rizk Assessment and Psychological Services
668 SE Bayberry Lane, Suite 101
Lee's Summit, MO 64063
(816) 260-6982

AUTHORIZATION FOR DISCLOSURE - GENERAL CONSENT FORM

Modified to reflect HIPPA of 1996 Rule (Section 164.508)

Client Name:____________________________________ Date of Birth:_________________________

I, _______________________________________, authorize Empowering Parents Inc.
Client name

To Disclose/Obtain/Exchange To/From:____
Name/Title of Person/Agency, include address

The following information from my service record: (Check all that apply)

☐ Consent to discuss diagnosis/treatment progress
☐ Client identification, treatment status and services applied
☐ Intake Summary
☐ Discharge Summary
☐ Psychological assessment/Psychiatric Assessment
☐ Physical examination and other medical data
☐ HIV (AIDS) related information
☐ Drug and Alcohol treatment information
☐ Discuss co-parenting counseling sessions/documentation
☐ Other (specify):____

The purpose for this disclosure request is:

☐ Referral to another agency/treatment center
☐ To complete evaluation/treatment
☐ Gain reimbursement
☐ To fulfill request from client's attorney
☐ For parole/probation
☐ To allow Co-parenting Counselor to testify in court
☐ To speak to and discuss my case with: my attorney / other parent's attorney / Guardian Ad Litem (circle all that apply)
☐ **Testimony**: I understand that in the event of a subpoena to testify and/or bring records to court, my therapist or parent aide will comply with the order of court and release private mental health information.
☐ Other (specify):____

Treatment or payment for services is not contingent on signing the Consent Form. The consent to disclose information from my records may be revoked by me at any time, unless to the extent that action has been taken in reliance thereon. This consent, unless expressly revoked earlier by me in writing terminates on ___________________________.

I understand that the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer protected by the Health Insurance Portability and Accountability Act of 1996. Empowering Parents is hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

PROHIBITION OF REDISCLOSURE: This information has been disclosed to you from records protected by Federal Confidentiality rules (42 CFR Part 2) and applies to alcohol and drug abuse information. The Federal rule prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. Turning Leaf Counseling *cannot be responsible for or protect any redisclosure*.

I understand that generally Empowering Parents may not condition my treatment on whether I sign a consent form, however that in certain limited circumstances I may be denied treatment if I do not sign a consent form.

____
Signature of Client Date

____
Signature of Witness Date

____
Signature of Parent/Legal Guardian (specify) Date