Stop Look and Listen LLC

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Authorization to use or Disclose Protected Health Information

Client Name________________ DOB____________ Phone_________________

Address_____________________________________________________________________________

I hereby authorize Stop Look and Listen LLC

To release to _______________________________________________________________________

To obtain from______________________________________________________________________

Dates of treatment or time period_______________________________________________________

The purpose for which disclosure is to be made, circle all that apply:

Co ordination of care, client request, and or for legal requirement and or other, (please specify):

___________________________________________________________________________________

Record Format (please specify): paper, data storage device

Information to be disclosed (please circle all that is applicable):

Diagnostic evaluation, Treatment Plan, Progress notes, Discharge Summary, Abstract includes address and contact information, Consultation or other, please specify,________________________________

I do not want the following information disclosed, please circle: alcohol/drug use/test, sexual abuse, sexually transmitted infections AIDS/HIV status.

I understand that my records are protected under the federal privacy laws and regulations and under the General Laws of Rhode Island and cannot be disclosed without my written consent except as otherwise specifically provided by law. I also understand that certain health records containing alcohol or drug abuse information may be subject to further protection under Federal Regulation 42 CFR Part 2, Confidentiality of Alcohol and Drug Abuse.

I understand that if the person(s) or entity (ies) that receive that receive(s) this information is not a health care provider or health plan covered by federal regulations, the information described above may be re disclosed and is no longer protected by those regulations. Therefore, I release Stop Look and Listen

LLC, its employees and my clinician/associates from all liability arising from this disclosure of health information.

It is my understanding that this authorization is for the information we have at the time of your request, only for the information requested above and will expire 1 year from the date signed below. I understand that I may revoke this authorization by notifying Stop Look and Listen in writing. I understand that any previously disclosed information would not be subject to my revocation request.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment or my eligibility for benefits, unless otherwise described in the space provided here:________________________________________________________________

Signature of Client, Legal Guardian and or Representative ________________Date/Time________