VISTA EAP/Intentions Yoga

Authorization to Release/Obtain Information

I, _____ [name of client], whose date of birth is ____/____/_____, authorize Vista Employee Assistance and Counseling Inc. / Cynthia N. Herzog, LCSW, CAP, ICADC, 500 E-RYT, and Clinical Director to disclose to and/or obtain from _____ [Person/Clinician/Organization] the following:

Description of Information to be Disclosed:

_____

_____

Purpose:
The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services. If other purpose, please specify below;

_____

_____

Revocation and Expiration
I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to my counselor _____. I further understand that a revocation of the authorization is not effective to the extent that action has already been taken in reliance on the authorization. Unless sooner revoked, this consent expires on the following date: ____/____/_____.

Conditions
I further understand that this Clinician/Organization/Physician, will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences: An inability on the part of my counselor to assess and/or provide the best possible care and treatment.

Form of Disclosure
Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally in paper format or electronically.

Redisclosure
Federal law prohibits the person or organization to whom disclosure is made from making any further disclosure of this treatment information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2 and 45 C.F.R. Other types of information may be re-disclosed by the recipient of the information if specific consent is obtained separate from this document.

I will be given a copy of this authorization for my records.

_____
Signature of Client Date

_____
Signature of Parent, Guardian, Personal Representative, Power of Attorney Date

_____
Signature of Witness Date

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