THE SOLUTION CENTER, LLC

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AUTHORIZATION FOR COORDINATION OF CARE

This form, when completed and signed by you, authorizes me to release protected information from your clinical record to the person you designate.

I authorize by social worker,_______________________________________, to release (Description of the information you want disclosed) ____
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This information should only be released to (name and address of person to whom the information is to be released)____

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You have the right to revoke this authorization, in writing, at any time, by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my social worker generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

____ ___________________________

Signature of Patient Date

If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided (e.g., Parent).

Clinical Member, American Association for Marriage and Family Therapy