Arden Shores
COUNSELING

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Authorization to Disclose Confidential Information

EMERGENCY CONTACT

I, (name) _____ (date of birth) _____, authorize and give my consent to Arden Shores Counseling, LLC to provide information to and from Arden Shores to and from the person/agency named below in the event of an emergency:

Name_____Relationship_____
Address _____
City/State/Zip_____ Phone _____

This confidential information may include (specify extent or nature of information to be disclosed):

> Presence in the clinic; circumstances of medical or other emergency; medical history; and current conditions.

The purpose for this exchange of information is to notify my identified emergency contact(s) of any medical or other emergency involving me, and my current whereabouts; and to assist in gathering any medical or other information necessary for emergency treatment.

I understand that mental health records are protected under Health Insurance Portability and Accountability Act (HIPAA) and cannot be disclosed by this office or re-disclosed by those receiving this information without my written consent, or as otherwise permitted by these regulations.

I understand that this form is optional and if signed will only be used in emergency situations. I also understand that I may revoke this release orally or in writing at any time, except for action already taken. This release will expire in 12 months from date signed, unless another date is specified.

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Client Signature Date