Consent to Release/Exchange Confidential Information

If you would like Dr. Ladi Boustani to coordinate care with another provider (your psychiatrist, primary care doctor, previous therapist, etc) complete this form to authorize release of protected health information (PHI).

I authorize Soul Therapy & Coaching/ Dr. Ladi Boustani and

_____

(Name of Organization/Therapist/Doctor)

_____

(Street)

_____

(City) (State) (Zip code)

_____

(Phone) (Email/Fax)

to exchange (in written and/or verbal form) the following: (initial each item to be disclosed)

- o History
- o Diagnosis
- o Assessment
- o Treatment
- o Date of Treatment
- o Medication Management
- o Educational Information
- o Discharge/ Transfer Summary
- o Continuing Care Plan
- o Progress in Treatment
- o Demographic Information
- o Emergency Contact
- o Psychotherapy Notes
- o Other (Please Specify) _____

Purpose: The purpose of this disclosure form of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services. This consent will be valid from the date of the consent forward unless rescinded by the patient.

Revocation: I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Soul Therapy & Coaching/Dr. Ladi Boustani. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration: Unless sooner revoked, this authorization expires on the following date: _____or as otherwise indicated: _____

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: I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulation, unless a State law applies that is more strict than HIPAA and provides additional privacy protections.

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

Patient Name:_____

Address: _____Phone:_____

Signature: _____Date: _____

_____

Signature of Parent, Guardian, or Personal Representative Date:

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.)