Quo Vadis Therapy Center, LLC

Located at Arden Woods Pscyhological Services

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Joseph W. Pribyl, MA, LMFT
900 Long Lake Road, #320
New Brighton, MN 55112
Phone: 651-398-5847
www.qvtherapy.com

I authorize:_____Joseph W. Pribyl, MA, LMFT_____
to use and disclose the specific protected health information described below regarding:

_____Date of Birth:___ _____
(Name)
as is necessary to: __ release information to, and/or ___ receive information from:

_____
(person/organization)

_____
address city/ state phone/fax/e-mail

The information to be used or disclosed includes:	YES	NO
Social, medical, or psychological reports.		
Medications used in treatment.		
Treatment goals and results.		
Information about drug and/or alcohol abuse or treatment		
Court or probation records		
Other:		
This information disclosure is necessary for the following purpose(s):	YES	NO
Diagnosis and evaluation.		
Treatment planning.		
To facilitate treatment.		
Other:		

If I am requesting this Authorization from you for our own use and disclosure or to allow another health care professional or health care entity to disclose information to us: (1) I cannot deny our services or treatment to you if you refuse to make this signed authorization; (2) You have the right to inspect a copy of the protected health information to be used or disclosed; (3) You have the right to restrict what information is disclosed with this Authorization; and (4) You have the right to revoke this Authorization at any time, provided that you do so in writing and except to the extent that I have already used or disclosed the information in reliance on this Authorization. Unless revoked earlier or otherwise indicated, this Authorization will expire **one year** from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

By signing this Authorization, you may be directing us to disclose your health information to a person or organization that does not have the same obligations to protect privacy required of health care practitioners, health plans and other health care entities observe under state and federal law. The disclosure of the information specified above may carry with it the potential for unauthorized/unintended disclosure by a third party of your protected health information and loss of protection under state and federal law.

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this authorization expires automatically as follows:

_____

(Specify the date, event, or condition upon which the Authorization expires if other than automatic expiration 1 year from the date this Authorization is signed.)

I have reviewed this Authorization and I understand it, as well as the pertinent information contained within the Informed Consent/Agreement to Psychotherapy Services, Policies, and Notice of Privacy Practices of Quo Vadis Therapy Center, LLC. I understand that the information used or disclosed under this Authorization may be subject to re-disclosure by the recipient, and that re-disclosed information may not be protected under federal privacy law.

_____

Client/patient (or) legal representative & legal representative's authority

_____

Date