Client Name:
DOB:

Section A: Use or Disclosure of Behavioral Health Information

I authorize the use and/or disclosure of my individually-identifiable **medical/school/work** to/from:
Name of Person/Agency: _____

Address:_____ Phone # _____ Fax #_____

I authorize Marvelous Light Consultants Counseling Services to: ☐ Obtain ☐ Release
medical/school/work records. ***MLC Office Address***: 5322 Snapfinger Dr. Suite B, Decatur, GA 30035
404-286-0054 (o); 404-286-0064 (f). ***For Privacy Protection mail to***: ***P. O. Box 1501, Lithonia GA 30058***

Section B: Scope and Use of Disclosure:

Information may be use/disclosed as follows **(Check One)**:

1. ☐ All health/school/work information about me, created or received by the Provider may include, if applicable:

- Information pertaining to the identity, diagnosis, prognosis or treatment for alcohol or drug abuse
- Information concerning the testing for HIV (Human Immune Virus) and/or treatment for AIDS (Acquired Immune Deficiency Syndrome) and any related conditions.
- Privileged communications between me and a physician psychiatrist, psychologist, licensed clinical social worker, licensed marriage and family counselor, licensed professional counselor, teachers, human resource personnel, employers, EAP/Insurance may be disclosed or released.

2. ☐ All medical/school/work information Except the following:_____
3. ☐ Specific health information that **Include** only the following: _____
4. ☐ **Community Linkage/Resources:** Providing linkage/resources does not guarantee that these services will be granted.

Participation may result in MLC/or community resource using images/photographs for public relations purposes i.e. on printed material (brochures, newsletters) or other media that include videos, website, or other media devices.

Section C. The purpose for this disclosure is: ☐ Continuity of Services ☐ Community Linkage/Resources

☐ **Other Reason:** _____

☐ **The consumer does not elect to disclose the purpose.** NOTE: This box may NOT be checked if the information to be disclosed pertains to alcohol or drug abuse information.

Section D. Expiration NOTE: If an expiration event is used, the event must relate to the consumer or the purpose for the disclosure.

Expiration Date of Release (mm/dd/yy) or Event_____

Section E. **Other Important Information**

1. I understand that Marvelous Light Consultants (MLC) cannot guarantee that the recipient of this information will not redisclose this information to a third party. The recipient may not be subject to federal laws governing privacy of health information. However, if the disclosure consists of treatment information about a consumer in an alcohol or drug abuse program, the recipient is prohibited under federal law from making any further disclosure of such information unless further disclosure is expressly permitted by written consent of the consumer or as otherwise permitted by federal law governing confidentiality of alcohol and drug abuse patient records (42 CFR, Part 2).
2. I understand that, except when I am receiving health care solely for the purpose of creating information for disclosure to a third party, I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment from MLC.
3. I understand that I may revoke this authorization in writing at any time, except that the revocation will not have any effect on any action taken by MLC in reliance on this authorization before written notice of revocation is received. (See Notice of Privacy Practices).

_____	_____	_____	_____AM/PM
Client' Signature	DOB	Date	Time
_____	_____	_____	_____AM/PM
Signature of Parent or Legal Guardian *(if applicable)*		Date	Time
_____	_____	_____	_____AM/PM
Signature of Witness (Title/Relationship to Client)		Date	Time

cc: Client' File