Andrea and Associates, LLC
Therapy Collective

1789 New Britain Avenue, Farmington, CT 06032
P: 860-754-3672 F: 860-855-6499 E: manage@andreateam.net

Authorization to Exchange Confidential Information

Name: ______________________________

DOB: __________
or
SSN: ______________________________

I understand that the purpose for this release is to assist with my/this client's treatment by allowing communication between professional service providers or agencies and the important individual(s) in my/this client's life. To further this goal, I authorize two-way written and/or verbal communication between Andrea and Associates, LLC and the individual(s) named below. The specific information to be disclosed is selected from below. I understand that my records are protected under Confidentiality of Alcohol and Drug Abuse Patient Records; C.F.R. Part 2, and cannot be disclosed without my consent.

The information to be disclosed is to be initialed by the client:

___ Name of Clinician
___ Admission / Discharge Information
___ Treatment Compliance / Attendance
___ Treatment Plan Information
___ Summary of Progress
___ Discharge Summary
___ Discharge Planning
___ Results of Biological Monitoring

The information selected is to be disclosed only to the person(s) listed below:

Name: ________________________________ Relationship: ______________ Phone: _______________

Address: ____ Email: ______________________________

I understand I may revoke this release at any time, except to the extent it has already been acted upon. This release will expire one year from the date signed, or under the following circumstances ____________________.

Client Name: _____________________________________ Signature: ____________________ Date: ________

Parent/ Guardian Name: ____________________________ Signature: ____________________ Date: ________

Witness Name: ____________________________________ Signature: ____________________ Date: ________

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Notice of Privacy Practices

1. Andrea and Associates, LLC, based on federal and state laws, is not allowed to disclose to **ANYONE** that you are a client at this agency, or release any part of your record, unless a signed authorization (or release) form is on file.
2. You have the right to refuse to sign any and all authorization forms.
3. If you decide not to sign an authorization form, please keep in mind that we will not be allowed to contact a person or organization that may require you to notify them when starting a treatment program. For example, if you are referred by the judicial system and do not sign an authorization form, the judicial system may assume you are non-compliant with its treatment recommendations.
4. There are circumstances where we **DO NOT** need an authorization form to disclose information. These include:
    - Suspicion of child abuse/neglect.
    - Suspicion of elder abuse.
    - Suspicion of abuse to a person who intellectually disabled.
    - Medical Emergencies.
    - If you threaten to harm yourself or others.
    - If Andrea and Associates or its staff has signed a Qualified Service Agreement signed contract with another agency that allows disclosure of information).
    - Internal communications.
    - Court-ordered subpoena (signed by a judge).
      State of federal audits (organizations visit us annually to make certain we are providing quality services and need to review charts)
    - Reporting crimes committed on premises or against staff
5. Authorized forms are specific. This office does not disclose information that you have not allowed in the signed authorization form.
6. ALL clinical records are destroyed 7 years after being closed (7 years from the time you are discharged from this office).
7. If you believe that any right has been violated, you may file a grievance at any time.
8. You may ask for this, or any form, to be explained at any time while you are engaged in treatment at this office. You may ask for an explanation as many times as you feel necessary.

______________________________	______________________________
Client Signature	Date
______________________________	______________________________
Staff Signature	Date

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CONSENT FOR RELEASE OF INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

I, ____, hereby authorize Andrea and Associates, LLC to use and/or disclose information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment and health care operations. I understand that while this consent is voluntary, if I refuse to sign this consent, Andrea and Associates, LLC can refuse to treat me.

I have been informed that Andrea and Associates, LLC has prepared a "Notice" which more fully describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment and health care operations. I understand that I have the right to review such Notice prior to signing this consent.

I understand that I may revoke this consent at any time by notifying Andrea Becker-Abbott, in writing, but if I revoke my consent, such revocation will not affect any actions Andrea Becker-Abbott took before my revocation.

I understand that I have the right to request that Andrea and Associates, LLC restricts how my individually identifiable health information is used and/or disclosed to carry our treatment, payment or health operations. I understand that Andrea and Associates, LLC does not have to agree to such restrictions, but that once such restrictions are agreed to, Andrea and Associates, LLC must adhere to such restrictions.

____ ______________________________

Signature of Client or Client's Representative Date

____

Printed Name of Client or Client's Representative

____

Relationship to Client