Rodney Orders, LICSW, LCSW-C, DOT-SAP
6236 Montrose RD
Rockville, MD 20852
(571) 308-8392

1350 Connecticut Ave, NW Ste 1225
Washington, DC 20036
(202) 596-2350

HIPAA AUTHORIZATION FORM

I, _____, whose date of birth is _____, authorize Rodney Orders,

LICSW, LCSW-C, DOT-SAP to disclose to and/or obtain from _____ the following information:

Description of Information to be Disclosed
(Patient/Client should initial each item to be disclosed.)

____ Diagnosis
____ Psychosocial Evaluation
____ Psychological Evaluation
____ Continuing Care Plan
____ Progress in Treatment
____ Other _____

Purpose
The purpose of this disclosure of information is to improve assessment and share information relevant to treatment and when appropriate, coordinate treatment services.

Revocation
I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Rodney Orders, LICSW, LCSW-C, DOT-SAP at the above address. 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 _____, 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.

Re-disclosure
Federal law prohibits the person or organization to whom disclosure is made from making any further disclosure of substance abuse treatment information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. I will be given a copy of this authorization for my records.

_____

Signature of Client/ Parent Date

_____

Signature of Clinician Date