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AUTHORIZATION TO SHARE PROTECTED HEALTH INFORMATION (PHI) BETWEEN PARTNERS

I, _____, date of birth _____, give permission to MARLENE TRAVIS to:

❑ **Share information with** ❑ **Receive information from** ❑ **Talk to**

Name: _____ Relationship: _____

Concerning myself and/or the following minor child(ren) of whom I am the parent or legal guardian:
Child's Name: _____ Date of Birth: _____
Child's Name: _____ Date of Birth: _____

I understand this information is essential to the continuity of care for myself or the above named individual and will be kept confidential and used for professional purposes only. The following kinds of information are requested/released for the purpose of coordination of care:

1) Freedom to exchange/share information between partners in the context of couples counseling.
2) Protection for therapeutic integrity of the relationship unit: If a secret-holding-client reveals a * "secret" to me directly, the secret-holder must reveal the secret to their significant other in order for the couple to continue in counseling as a couple. Without said disclosure, the therapeutic relationship will terminate for one and/or both individuals.

I am aware that my records may contain health care information relating to testing, diagnosis, or treatment for HIV/AIDS or for any other STD, for chemical dependence, and/or mental health. **My initial next to each item below indicates my intention to release the specified information.**

_____ Mental health (diagnosis, treatment plan, symptoms, medications)

_____ HIV/AIDS _____ Sexually transmitted diseases _____ Chemical dependency

Copies of this document may be considered the same as the original.

I understand that I may revoke this authorization in writing at any time; that the Provider will make a Revocation of Authorization form available to me; that such revocation will not be effective to the extent that substantial action may have already been taken in reliance on this authorization, including provision of health care services requiring subsequent disclosure to effect payment.

I understand that re-disclosure of my health information by the Recipient, if unauthorized, is a potential risk. If re-disclosed, privacy laws may no longer protect the information. I understand that I do not have to sign this authorization in order to obtain treatment benefits from the Provider, except for health care services necessary to create any assessment or report contemplated by this authorization. I understand that I am entitled to a copy of any authorization I sign.

The effective date of this authorization will be the date of my signature below. If not previously revoked, this authorization will expire upon the following date: _____, event: _____

or ninety (90) days following termination of treatment and when account is paid in full.

Client's Signature_____ Date_____

**Secrets* refers to undisclosed past or present (emotional or intimate) affairs affecting the current relationship, domestic violence or abuse, undisclosed intent to separate/divorce, active self-harm plans, and undisclosed/ untreated addictions to name a few.