SUSAN DAVIS MSW, RMT, RM
168 Battery Street, Burlington VT 05401
802-373-3420
davismassageandwellness.com

# TREATMENT COLLABORATION INFORMATION RELEASE AUTHORIZATION

I,_____whose Date of Birth is _____ ,
Name of patient/Client
authorize Susan Davis, CMT, MSW, RM to share treatment information with:
_____(Name/Title of Person and Organization)
for the purposes of coordinating treatment services by sharing information relevant to treatment and assessment. Confidential collaboration ideally improves treatment planning and outcome.

**(Patient/Client should initial each item to be disclosed)**

_____ Assessment
_____ Diagnosis
_____ Psychosocial Evaluation
_____ Psychological Evaluation
_____ Psychiatric Evaluation
_____ Treatment Plan or Summary
_____ Current Treatment Update
_____ Medication Management Information
_____ Presence/Participation in Treatment
_____ Educational Information
_____ Discharge/Transfer Summary
_____ Continuing Care Plan
_____ Progress in Treatment
_____ Psychotherapy Notes*
*(*Cannot be combined with any other disclosure)*

_____ Other _____
_____ Other _____

**Marketing/ Sale of Information** -- None of the information within this authorization form will be used for marketing, research, or sold.

**Revocation** -- I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Susan Davis, CMT, MSW, RM, otherwise it will expire on the following date: _____or as otherwise indicated.

**Conditions** -- I further understand that Susan Davis, CMT, MSW, RM. will not condition my treatment on whether I give authorization for the requested disclosure.

**Form of Disclosure** -- Unless a specific request in writing has been submitted to Susan Davis requesting that the disclosure be made in a certain format, this authorization allows the disclosure of information in any manner deemed to be appropriate and consistent with confidentiality, applicable law, including, but not limited to, verbally, in paper format or electronically.

I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient, and the protected health information may no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections.

I will be given a copy of this authorization for my records upon request.

_____

Signature of Patient/Client Date

_____

Signature of Susan Davis, CMT, MSW, RM. Date