Couples Rights and my approach

If you are coming to treatment as part of a couple:

1. I will require full and unrestricted releases for both members for each other. In addition, I will require an emergency contact for each person that is not the other member of the couple.
2. I am not here to save your relationship. I am here to help you decide for yourselves what is best for your relationship and how best to move forward. That means either together or separately.
3. I will probably start seeing you as a couple for at least the first 3-4 sessions. Normally after that I may start seeing you on same session, but separately. This doesn’t happen all the time, but I may decide in the course of treatment to see the couple as brief individual sessions.
4. I may assign homework. You don’t have to do it, but I highly recommend you do. Depending on what brings you into treatment I may recommend books on communication, love, anger, infidelity, needs in a relationship, or trust.
5. I will not keep secrets from the other person. If you tell me something like “please don’t tell him/her this but…” I will not guarantee anything. For two reasons: I can remember well what people tell me, but I can’t remember the things I’m told not to talk about. The other reason is I’m not a friend, I’m a counselor. If I take sides I’m not doing either person any service.
6. I will do my best not to take sides. It takes 2 people to make a relationship and two people to break a relationship. I will do my best to stay objective. It may be possible that one person may bear more of the responsibility for the state of the relationship than the other, so if one person gets more attention, that may be a symptom of who bears more of the responsibility.
7. Please talk to each other in session, not about each other.
8. Be aware of the volume and content of your language in session. This facility is used by families, people with special needs and children.
9. Social media and reviews: Should you choose to post, like, review, comment, etc., on any online or print forum/platform, anything related to myself or my practice, please understand you may be publicly giving up your confidentiality as a client of mine. You do so at your own risk.
10. I am a mandated reporter for abuse and violence. I strongly urge either party that if you are experiencing violence of any sort to call the police. If you can’t and you inform me, I WILL call the police. It is not my responsibility as a mandated reporter to be able to prove physical harm or violence, ALL I HAVE TO DO IS SUSPECT IT. It is better I err in caution than risk a client be harmed/maimed/or killed. I HAVE TO act if I suspect violence is going to happen or that it is being hidden from me. I HAVE TO act if I’m told be either party that the violence continues to happen. Our counseling relationship is not as important as your life. If it means the end of our counseling relationship, I will offer referrals.
11. If you have children, the above applies to them. As a mandated reporter, all I have to do is SUSPECT child abuse or neglect and I must call the police. I DO NOT have to prove it.
12. If your relationship ends, I WILL NOT see both people as individual clients. You can continue coming to me as a “Couple” but I cannot see both of you as individual clients. I can offer a referral if one decides to seek treatment elsewhere.

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Signature 1 date Signature 2 date Counselor date

Larry Epstein Mental Health PLLC

**302 Willis Avenue**

**Mineola NY 11553**

**(O)516-325-5617 (F)516-741-8456**

### Full Release of Information for a Partner/Spouse

I hereby authorize Larry Epstein LMHC CASAC to exchange information with:

Name: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The information requested or authorized for release is a full release pertaining but not limited to:

Emergency contact

Confirm appointments

Toxicology results

Admit date

Discharge status

Discharge date

Progress of Treatment/counseling

Answer drug/alcohol abuse questions

This authorization is valid for 1 year from the date provided below or **\_\_\_\_\_\_\_\_\_\_\_**, whichever is earlier. I may cancel this authorization by signing, dating, and writing “CANCEL” on this original form, by sending a written, signed and dated request to the counselor above indicating my desire to cancel or verbally informing him of my desire to rescind this release. I understand that once my information has been released, the recipient might re-disclose it, my counselor has no control over it and privacy laws may no longer protect it. The purpose of this authorization is to improve the quality of my mental health evaluation or treatment.

I understand that my records are protected under the Federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), 45 C.F.R. pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it. Unless I revoke my consent earlier, this consent will expire automatically as follows:

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

#####  Client’s Name Date of Birth

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

#####  Client’s Signature Today’s Date

Larry Epstein Mental Health PLLC

**302 Willis Avenue**

**Mineola NY 11553**

**(O)516-325-5617 (F)516-741-8456**

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Name: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Emergency contact

Confirm appointments

Toxicology results

Admit date

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#####  Client’s Name Date of Birth

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#####  Client’s Signature Today’s Date

Larry Epstein Mental Health PLLC

**302 Willis Avenue**

**Mineola NY 11553**

**(O)516-325-5617 (F)516-741-8456**

### Release of Information to third party insurance company

I hereby authorize Larry Epstein LMHC CASAC to exchange information with:

Name: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship: Insurance provider

The information requested or authorized for release or exchange pertains to:

Confirm Appointments

Toxicology Results

Progress of Counseling

Admit Date

Discharge Date

Discharge Status

Provide/Discuss Diagnosis

Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that my records are protected under the Federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), 45 C.F.R. pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it. Unless I revoke my consent earlier, this consent will expire automatically as follows: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.
 *[describe date, event, or condition upon which consent will expire, which must be no longer than reasonably necessary to serve the purpose of this consent]*

I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

I have been provided a copy of this form.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

#####  Client’s Name Date of Birth

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#####  Client’s Signature Today’s Date