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Authorization for Use or Disclosure of Protected Health Information

Client Information

Client Last Name ________________________ First Name __________________ MI ___ DOB: ___ /___ /____

Client Address ____

Client Home Phone: ____________________________ Cell/Work Phone: ______________________

Client Email Address: _____________________________________

Recipient Information

I, __________________________, do hereby authorize ___________________________ to release a copy of my mental health information to the person or facility below.

Name of person/facility to receive medical information: ______________________________Phone: ______________________

Address: ____

Date of Authorization: ___/___/______ Authorization to expire on ___/___/______ or upon the happening of the

following event: __________ ____

Information to be Released

(Note: Requests for release of psychotherapy notes cannot be combined with any other type of request.)

__My entire mental health record
__Only those portions pertaining to: ____
(Specific provider name and/or dates of treatment)
__Authorization for Psychotherapy Information ONLY.
(Important: If this authorization is for Psychotherapy Notes, you must not use it as an authorization for any other type of protected health information.)
__Other: ____

Purpose of Information Release

__Further mental health care
__Payment of insurance claim
__Legal investigation
__Applying for insurance
__Vocational rehab, evaluation
__Disability determination
__At the request of the individual
__Other (specify): ____

Authorization and Signature

I authorize the release of my confidential protected health information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected health information.

____ ___________________
Signature Date

If signed by a personal representative:

Print your name: ____
Indicate your relationship to the client and/or reason and legal authority for signing:

Patient is: ___minor ___ incompetent ___disabled ___deceased
Legal authority: ___Parent ___ legal guardian ___ representative of deceased