Authorization for Use or Disclosure of Protected Health Information

Client Information

Client Last Name:_____ First Name: _____M.I._____

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 Notes 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:

(a) Print your name: _____

(b) 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