Authorization for Use or Disclosure of Protected Health Information

Client Information:

Client Full Name: ____ DOB:____/_____/_____

Street Address: ____

City: ___________________________________ State: _____________ Zip Code: __________________

Phone Number: ________________________________

Recipient Information:

Name of person/facility: ____

Street Address: ____

City: ___________________________________ State: _____________ Zip Code: _____________________

Phone Number: ________________________________ Fax Number: _________________________________

Information to be Released:

- □ Diagnosis
- □ Dates of Service
- □ Initial Assessment Note
- □ Mental Health Progress Notes
- □ Substance Abuse Treatment Information
- □ Summary of Treatment
- □ Entire Mental Health Record
- □ Other: ____________________________

Purpose of Information Release:

- □ Coordination of care
- □ Referral to another provider
- □ Personal use of Records
- □ Involvement of parent or other significant other in treatment
- □ Coordination with School or Legal System
- □ Other: ___________________________

I hereby authorize __________________________________ to release a copy of the mental health information indicated to the person or facility above. I understand that this authorization permits my health information to be released and exchanged verbally and/or in written form.

I authorize the release of my confidential protected health information, as directed above. I understand that this authorization is voluntary, that the information to be disclosed is protected by Federal and state law and cannot be disclosed without my consent unless otherwise provided. I understand that I may revoke this consent at any time and must do so in writing. A request to revoke this authorization will not affect any actions taken before the provider receives the request.

This consent will expire one year from the date of signature below.

____ ___________________________________

Signature of Patient or Legally Authorized Representative *Date*

____ ___________________________________

Print Name *Relationship if not signed by patient*