Authorization for Use or Disclosure of Protected Health Information

Client Information

Last name_____First name_____ MI_____
DOB: ___/___/____
Address:_____
_____
Client home phone_____ Cell_____ Work_____
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 to receive 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 can not be combined with any other type of request)*

____ My entire mental health record
____ Only those portions pertaining to _____
Specify 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 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 information ____Disability determination
____At the request of the individual
____Other (specify)_____

Authorization and signature

I authorize the release of my 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 that 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 health information.

_____ _____

Signature Date

If signed by a personal representative:

(a) Print your name _____

(b) Indicate your relationship to the client

Patient is: __ Minor ___ Incompetent ___Disabled ___Deceased

Legal authority:

___Parent ___Legal guardian ___Representative of deceased