AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION PURSUANT TO HIPAA

Printed Client Name:	Date of Birth:
Address: ______________________________	Telephone:

I hereby authorize:

____

Provider Name/Organization/Individual and address to release the information — Provider's Telephone Number

to release written, oral or electronically transmitted protected health information indicated below on the above named individual to:

____

Provider Name and address to whom this information will be sent — Provider's Telephone Number

Relating to treatment dates from ________________________ to _________________________

☐ Information may be exchanged between these providers

Expiration Date: _____________________
Not to exceed 1 year

INFORMATION TO BE DISCLOSED:

Assessment	Treatment/Services	Other
____Psychiatric	____Treatment Plan	____Discharge Summary
____Psychological	____Treatment Progress	____Dates of Service
____Psychological test reports	____Psychiatry Notes	____Lab Results
____Intake	____Progress Notes	____Complete copy of clinical record
____Other:		____Other:

____HIV Documentation______________(must initial)

I understand that:

- **The information in y health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS, or human immunodeficiency virus (HIV).**
- I have the right of access to inspect and obtain a copy of my protected health information.
- I have a right to revoke this authorization at any time. If I revoke this authorization, I must do so in writing to my therapist.
- Revocation will not apply to information that has already been released in response to this authorization.
- Re-disclosure is prohibited unless the person who consented to the disclosure specifically consents to re-disclosure. However, once the above information is disclosed, there is the potential that it may be re-disclosed by the recipient, and therefore may not be protected by the federal privacy laws regulations.
- Failure to provide all required information will not constitute a proper authorization to disclose protected health information and, therefore, my request may not be honored.
- Authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment, payment or eligibility for benefits.

Signature of Patient	Date	Signature of Parent or Legal Representative	Date
Witness Signature	Date		

(Patients 12 to 17 years of age must sign in addition to the Parent or Legal Representative)
(If signed by a legal representative, indicate the relationship to patient or authority to act for patient).
Fee/charges will comply with all laws and regulations applicable to release protected health information.

FOR OFFICE USE: Date received:___________________ Date completed:___________________
When applicable, the identity of the Legal Representative was verified by the following documentation: Driver's License___ Picture ID___ and established that in his/her capacity, the above named legal representative is authorized to act on behalf of the patient: Court Appointed Legal Guardian ___ Power of Attorney ___ Executor of Estate___ Other:____

Revised 02/2012