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Authorization to Use and Disclose Protected Health Information

1. I am completing this form to allow the use and sharing of protected health information about

Printed name: _____ Date of Birth: _____SSN: _____

2. I authorize this person or organization _____

3a. To use, disclose, request, or exchange the following information:

- ☐ Inpatient or outpatient treatment records for physical and or psychological, psychiatric, or emotional illness.
- ☐ Admission and discharge summaries
- ☐ Psychological or psychiatric evaluation(s), reports, assessments, treatment notes, summaries, or other documents with diagnoses, prognoses, recommendations, or testing records, and behavioral observations or checklists completed by any staff member or the patient, or similar documents.
- ☐ Complete copy of the medical record.
- ☐ Other: _____

3b. Dates of care included: From _____ to _____

4. To/From this person or organization _____

5. The information will be used/disclosed for the following purposes: _____

6. I understand and agree that this Authorization will be valid and in effect until _____ . I understand that after that date or event, no more of this information can be used or released to the person or organization unless I sign a new Authorization like this one.

7. I understand that I can revoke or cancel this authorization at any time by sending a letter to the Privacy Officer of the organization listed above and which is to supply this information. If I do this, it will prevent any disclosures after the date it is received but cannot change the fact that some information may have been sent or shared before that date.

8. I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from the professional or facility listed at number 2, above, nor will it affect my eligibility for benefits.

9. I understand that I may inspect and request a copy the health information described in this authorization. There may be a cost for this copy or other services.

10. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by those regulations.

12. I affirm that everything in this form that was not clear to me has been explained and I believe I now understand all of it.

13. I recognize that by sending this form by any other means (including email, photograph, fax, or other means) other than hard copy provided directly to mental health professional, may result in the accidental release of personal and protected information for which I will not hold the mental health professional liable.

As the person signing this authorization, I understand that I am giving my permission to the above-named health care entity for disclosure of confidential health records. I understand that the health care entity may not condition treatment or payment on my willingness to sign this authorization unless the specific circumstances under which such conditioning is permitted by law are applicable and are set forth in this authorization. I also understand that I have the right to revoke this authorization at any time, but that my revocation is not effective until delivered in writing to the person who is in possession of my health records and is not effective as to health records already disclosed under this authorization. A copy of this authorization and a notation concerning the persons or agencies to whom disclosure was made shall be included with my original health records. I understand that health information disclosed under this authorization might be redisclosed by a recipient and may, as a result of such disclosure, no longer be protected to the same extent as such health information was protected by law while solely in the possession of the health care entity.

_____ _____

Signature of client or his or her personal representative **Date**

_____ _____

Printed name of client or personal representative **Relationship to the client**

13.I, a mental health professional, have discussed the issues above with the client and/or his personal representative. My observations of his or her behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent

_____ _____ _____

Signature of professional Printed name of professional Date