Authorization for Use, Disclosure, or Exchange of Protected Health Information

Client Information

Client Last Name_____ First Name _____MI ___
DOB: ___/___/____
Client Address
_____
Client Home Phone: _____ Cell/Work Phone:_____
Client Email Address: _____

Recipient Information

I, _____, do hereby authorize _____ to release, disclose, or exchange my mental health information to the person or facility below.

Name of person/facility to receive, disclose, or exchange 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
□ Applying for insurance
□ At the request of the individual
□ Payment of insurance claim
□ Vocational rehab, evaluation
□ Other (specify): _____
□ Legal investigation
□ Disability determination

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