

Authorization for Use or Disclosure of Protected Health Information

Client Information

Client Last Name _____ First Name _____ MI _____ DOB: ____/____/____

Client Address _____

Home Phone: _____ Cell/Work Phone: _____ 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/facility to receive 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:

- | | | |
|---|---|---|
| <input type="checkbox"/> Further mental health care | <input type="checkbox"/> Payment of insurance claim | <input type="checkbox"/> Legal investigation |
| <input type="checkbox"/> Applying for insurance | <input type="checkbox"/> Vocational rehab, evaluation | <input type="checkbox"/> Disability determination |
| <input type="checkbox"/> At the request of the individual | <input type="checkbox"/> Other (specify): _____ | |

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

