Authorization to Release Protected Health Information

Name:_____Patient Address:_____
Patient DOB:_____ Patient Phone:_____
I authorize _____
Name of Physician/Therapist/Healthcare Agency
_____
Address of Physician/Therapist/Healthcare Agency Phone of Physician/Therapist/Agency

To release the protected health information checked below: ☐ Psychotherapy Notes ☐ Assessment ☐ Diagnosis ☐ Psychosocial Evaluation ☐ Psychological Evaluation ☐ Progress in Treatment ☐ Demographic Information ☐ Treatment Plan or Summary ☐ Current Treatment Update ☐ Presence/Participation ☐ Educational Information ☐ Discharge/Transfer Summary ☐ Dates of services with corresponding charges ☐ Financial balances (able to accept payment from authorized party identified on this form.) ☐ Other

Name of person to whom records should be released:_____
Address:_____
Phone:_____ Fax:_____

Reason for Release: To coordinate care when appropriate, and share information to support assessment, treatment and treatment planning.
Revocation: I understand that I have the write to revoke this authorization at any time when I send written notification to my provider at the respective office where I render services. I further understand that a revocation of authorization is not effective to the extent that action has been taken in reliance of this authorization.
Expiration: Unless revoked in writing, this authorization expires 365 days from the date of signature.
Conditions: I understand that my signature on this authorization has no relationship to my ability to receive treatment, payment, enrollment or eligibility of benefits.
Form of Disclosure: Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner deemed appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.
Redisclosure: I understand that there is the potential for protected health information that is disclosed pursuant to this authorization to be re-disclosed by the recipient, and protected health information will no longer be protected by HIPAA privacy regulation, unless a state law applies that is stricter than HIPAA and provides additional privacy protections. A copy of this authorization will be provided upon your request.

PRINT NAME OF CLIENT:_____
SIGNATURE OF CLIENT:_____
Date:_____