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AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Client Name: _____ **Date:** _____

I authorize my psychologist _____

to: (initial all that apply)

_____ Receive a copy of my specific health information from the person(s) named below

_____ Send a copy of my specific health information to the person(s) named below

To/From: _____

_____

(Name, address and phone number of person who will send or receive information)

I authorize this information to be used for: (initial all that apply)

_____ Mental health session notes _____ Billing records _____ School records

_____ Mental health treatment summary _____ Psychological evaluation reports

_____ Other *(specify)* _____

_____ Other medical records *(specify)* _____

I understand that any information that is exchanged with another person will be protected if that person is required to comply with the Federal Privacy rule. If privacy laws do not apply, the information may not be protected and could be re-disclosed without authorization.

I understand that I may refuse to sign this authorization. My refusal to sign will not prevent me from receiving mental health services or reimbursement for services. The only exception is if the services are solely for the purpose of providing information exchanged before I revoke this authorization cannot be retrieved. To revoke this authorization, please send a written statement revoking the authorization to: _____

Unless revoked, this authorization will expire in (initial one):

_____ one year _____ on termination of mental health treatment

_____ other *(indicate expiration date or event):* _____

I have read this authorization and I understand it. This completed authorization must be signed by the client or a person authorized by law to represent the client. A copy of this authorization is as valid as the original.

_____ _____

Signature of Client or Client's Representative **Date**

Description of representative's authority: _____