Authorization for Disclosure of Mental Health Trea

I, Client Legal Name - First, Last **hereby voluntarily authorize the disclosure of information from my health record.**

The information is to be disclosed by:

NAME OF FACILITY

STREET OR MAILING ADDRESS

CITY/STATE/ZIP

PHONE

FAX NUMBER

And is to be provided to:

NAME OF PERSON/ORGANIZATION/FACILITY

STREET OR MAILING ADDRESS

CITY/STATE/ZIP

PHONE

FAX NUMBER

The purpose or need for this disclosure is:

- [ ] Further medical Care
- [ ] Personal Use
- [ ] Attorney
- [ ] Insurance
- [ ] School
- [ ] Disability
- [ ] Research
- [ ] Health Information Exchange
- [ ] Other* Please Specify

If 'Other' Please Specify Here:

The information to be disclosed is:

New Checkbox List

- [ ] Limited to Specific Information
- [ ] Limited to distinct date range
- [ ] The entire record

If Information is limited, please List Details

A description of the information to be disclosed is the following:

Check any of the following:

- [ ] Assessment
- [ ] Diagnosis
- [ ] Psychological Evaluation
- [ ] Psychosocial Evaluation
- [ ] Treatment Plan or Summary
- [ ] Current Treatment Update
- [ ] Medication Management Information
- [ ] Presence/Participation in Treatment
- [ ] Nursing/Medical Information
- [ ] Education Information
- [ ] Discharge / Transfer Summary
- [ ] Continuing Care Plan
- [ ] Progress in Notes
- [ ] Demographic Information

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization

Expiration

Unless sooner revoked, this authorization expires 6 months from the date of this authorization.

Conditions

I further understand that this entity will not condition my treatment on whether I give authorization for the requested disclosure.

Form of Disclosure

If you desire, you may limit the disclosure to one of the following methods:

Choose Any that Apply

- ◯ Verbal Only
- ◯ Paper or Electronic Only
- ◯ No preference of method of disclosure

Redisclosure

I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipiet and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protection.

Signature of Patient/Client

Date

mm/dd/yyyy

Signature of Parent/Guardian/Representative**

Date

mm/dd/yyyy

**If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc)

Describe here: