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AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION	
NAME OF CLIENT:	
DATE OF BIRTH:	
SSN:	
PHONE #:	
ADDRESS:	
CITY, STATE, ZIP CODE:	

I authorize the use and release of my protected health information to:

NAME:	
PHONE #:	
FAX #:	
ADDRESS:	
CITY, STATE, ZIP CODE:	

Form in Which Information Should be Released: □ Verbal □ Written □ Email □ Other:_____

Information to be released: From Date: _____ To Date: _____

□ Mental Health Record in its entirety
□ Only specific information (Only items checked below to be released):

□ Diagnosis	□ Scheduling/Appointments	□ Billing Information
□ Progress Notes	□ Treatment Plan	□ Other:_____

1. I understand that this authorization will expire one year from my last date of service visit. A photocopy of this form will be considered as valid as the original.
2. I understand that I may revoke this authorization at any time by notifying my provider at the address indicated above, in writing, and this authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it.
3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations. However, other state or federal law may prohibit the recipient from disclosing specialty protected information, such as substance abuse treatment information, HIV/AIDS-related information, and psychiatric/mental health information.
4. My health care and payment for my health care will not be affected if I do not sign this form.
5. I understand that my refusal to sign this authorization will not jeopardize my right to obtain present or future treatment for mental health concerns, except where disclosure of the information is necessary for the treatment.

By signing below, I acknowledge that I have read or understand this authorization.

_____ _____
Signature of Client Date

_____ _____
Parent/Legal Guardian Date

_____ _____
Witness Date