**Authorization for Release of Protected Health Information**

Full Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The person named above Authorizes:

Provider and/or Organization \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address ­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State, Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Check all that apply:

[ ]  to request protected health information from: [ ]  to send protected health information to:

[ ]  to discuss protected health information with:

Provider and/or Organization \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address ­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City State Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This protected health information will include (Check all that apply):

[ ]  All information regarding assessment, diagnosis, and treatment of patient’s condition.

[ ]  All information regarding care received by the patient from \_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_.

[ ]  Information regarding mental health care. [ ]  Information about Substance abuse.

[ ]  Psychotherapy notes [ ]  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This authorization will expire (Check only one): [ ]  In one year. [ ]  When information is received. [ ]  When services are ended.

Authorizing Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_

Check One: [ ] Patient, [ ]  Parent or Guardian of Minor Child, [ ]  Court Appointed Guardian\*

 [ ]  Power of Attorney\*

\*Copies of Documents should be attached

In signing this authorization, you have certain rights.

1. You have the right to refuse to sign this authorization and to refuse to have any or all records released.
2. You have the right to revoke this authorization at any time by submitting a written request to our practice.
3. You have a right to a copy of this authorization on request.
4. You have the right to inspect the information before it is released. (Please see our Notice of Privacy Practices for other specific rights about your health information.)

Other Information About Records Release:

We will only release records that we created. We will never release any information we receive from other providers and organizations.

Providers or organizations receiving information from us should never release this information to anyone else.

If you refuse to sign this authorization or later revoke this authorization, it will not affect your ability to receive services from us except to the extent that this release or information may be necessary to provide you with appropriate care.

There may be a fee for copying your records. For personal use you are entitled to one copy without charge. Additional copies or copies to others are billed at $0.50 (fifty cents) a page.

A copy of this form (electronic or paper) is as valid as the original.