Ivyland Counseling Center

1210 Old York Road • Suite 202 • Warminster • PA 18974 • 215.444.9204

Authorization to Release Confidential Protected Health Information (PHI)

_____ _____/_____/_____ _____-_____-_____

Client's Name Date of Birth Social Security Number

I authorize: _____

Name of Provider

To release information obtained during the course of contact with Ivyland Counseling Center to:

_____ _____

Facility Name Person to Receive Information

Address where records are to be sent:

_____

Street Suite City State Zip Code

The disclosure of records authorized herein is required for the following specific purpose:

_____

_____

_____

The following specific types of information are requested for the above purpose; disclosure shall be limited to the minimum specific types of information that pertain to the purpose of this authorization:

☐ Diagnosis ☐ Prognosis ☐ Progress Notes ☐ Dates of Treatment ☐ Evaluation/Assessment
☐ Medication ☐ Side Effects of Medication ☐ Medical History Reports ☐ Lab Results
☐ Other:

_____

Please specify "other information" and the specific purpose for which it is needed

An additional AUTHORIZATION must be obtained for any other transfer or disclosure of information. I understand that this Authorization is subject to cancellation by the undersigned at any time except to the extent that action has already been taken. I further understand that cancellation of this authorization must be in writing to the treating professional and that this action will not affect my right to further treatment or my right to future treatment.

If not cancelled earlier, this Authorization shall terminate 90 days from the date on which the Authorization is signed, or:
☐ On completion of this request ☐ One year or end of treatment (whichever comes first).

I understand that I have a right to receive a copy of this Authorization if I so request. I also understand that it is possible that the information disclosed by this Authorization may be re-disclosed by the facility or individual receiving it and, thereby, may not be further protected by Federal confidentiality law (HIPAA). However, federal law generally prohibits further disclosure of it unless another authorization for such disclosure is obtained from me or is specifically required or permitted by law. **For substance abuse PHI, see the note below.**

DATE: _____ WITNESS: _____

(Staff witnessing signature will sign as witness.)

SIGNED: _____ * _____

*If signed by other than client, indicate relationship. Parents must have legal custody. Legal guardians and conservators must show proof of status.

NOTE: Information disclosed pursuant to this release is protected by federal confidentiality rules (42 CFR Part 2). Federal rules prohibit further disclosure of this information unless disclosure is expressly permitted by the written consent of the person to whom it pertains or otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. Federal rules restrict any use of the information to investigate criminally or prosecute any alcohol or drug abuse patient.