



growththerapy

Email: records@growththerapy.com

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION (MENTAL/BEHAVIORAL MEDICAL RECORDS)

Completion of this document authorizes the disclosure and/or use of mental health information about you. Failure to provide all information requested may invalidate this authorization.

PATIENT INFORMATION

Patient Name: _____ DOB: ____/____/____

Email: _____ Phone: _____

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

The party below may disclose health information:

Grow Therapy (Optional - Specify provider: _____)

Information may be disclosed to the following recipient:

Name of Person/Entity: _____

Phone: _____ Fax/Email: _____

Street Address City State Zip Code

I authorize disclosure of the health information described below (check all that apply):

Date(s) of Service / Date Range: _____

All records regarding my mental/behavioral health treatment

OR

Progress notes

Psychiatric evaluation

Billing records

Medications

Treatment Summary

Other: _____

Discharge Summary

The purpose of this use or disclosure (check one):

- Patient request Continuity of care
 Insurance Other (*please specify*):
 Legal _____

Expiration: This authorization shall be effective immediately and will expire one (1) year from the date signed unless another date is specified below:

Optional - Alternate expiration date: ____/____/____

RIGHTS & ACKNOWLEDGEMENTS

I understand I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.

I understand that I may revoke this authorization at any time, but I must do so in writing and submit it to the following address:

records@growththerapy.com. My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.

I understand that information used or disclosed pursuant to this authorization could be re-disclosed by the recipient and may no longer be protected by state or federal confidentiality law (HIPAA).

SIGNATURE

Signature: _____ Date: ____/____/____

If signed by someone other than the patient, please provide your printed name and indicate your legal relationship to the patient:

Printed Name: _____

Relationship to patient:

- Guardian Healthcare Power of Attorney (POA) *
 Other legally authorized representative * (*specify*): _____

** Document(s) demonstrating legal authority (ex: healthcare POA) must be provided along with this form to avoid processing delays.*