Reflect In Motion
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AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION

Patient Name: _____ DOB: _____

Address: _____

_____

Home Telephone: _____ Cell Phone: _____

Therapist Name: _____

Phone Number: _____

I, _____, give my permission for Beth Smith, LCSW-C at Reflect In Motion, to disclose to and receive from the following individual or organization information pertaining to my health (my "protected health information" or "PHI"), including information related to my current and previous psychotherapy or hospitalization, and any of my medical records given to Reflect In Motion by another health care provider who has not prohibited re-disclosure of the record:

Name: _____

Address: _____

_____

Phone Number: _____ Fax Number: _____

I permit the above-referenced disclosures for the following purposes:

_____

[*Statement of specific purpose(s), e.g., "any purpose relating to my health, the payment for my health care, the study of mental health, research on the relationship between mental and physical health," etc.*]

I understand that once my PHI is shared based on this authorization, federal privacy law may not prevent the persons or entities receiving the information from further disclosing it to

others. I also understand that I have the right to revoke this authorization at any time by sending a written notice of my revocation to Reflect In Motion at the address at the top of this page. Such revocation will prohibit reliance on this authorization after the date upon which Reflect In Motion receives the notice, but I understand that the use and re-disclosure of PHI already disclosed prior to that date will not be subject to the revocation.

I understand that Reflect In Motion may not condition my medical treatment or eligibility for medical benefits on my agreement to sign this authorization.

This authorization will remain in effect until _____ or one year after the date of my signature below, whichever is sooner.

[Name of Patient]	Signature	Date
[Name of legal representative] *Authorized as [legal guardian or other] to act on behalf of [name of patient*]	Signature	Date

SIGNED COPY OF AUTHORIZATION TO BE PROVIDED TO PATIENT