Authorization to Release or Obtain Health Information

(including paper, oral, and electronic information)

Name:	Request Date:
Mailing Address:	Date of Birth:
City/State/Zip:	Legal Guardian if applicable:

I authorize:

Name: ______________ **DAYBREAK THERAPY SOLUTIONS** ______________

Mailing Address: ________ **1234 Del Este Ave. #502** ________

City, State, Zip Code: ______ **Denham Springs, LA 70726** ______

Relationship: **Behavioral Health Provider** Phone Number: **Ph: 225-320-3223 / Fax: 225-380-2196**

☒ **TO RELEASE information TO** **AND/OR** ☒ **TO OBTAIN information FROM**

(Place an "X" in the box that indicates if the information is being released OR requested.)

Name: ____

Mailing Address: ____

City, State, Zip Code: ____

Relationship: ______________________________ Phone Number: ____________________

The **Purpose of this Authorization** is indicated in the box(es) below. (Place an "X" in the box(es) that apply.)

☐ Further Medical Care ☐ Personal ☐ Legal Investigation or Action ☐ Changing Providers
☐ School Collaboration ☐ Creating health information for disclosure to a third party
☐ Treatment Coordination ☐ Other: ____

I authorize the release of the following protected health information. (Place an "X" in the box(es) that apply to the information you want released or you want to obtain.)

☐ Entire Record ☐ Medical History, Examination, Reports ☐ Diagnoses ☐ Prescription(s)
☐ Evaluations, Tests, Assessments ☐ Treatment Plan(s) and/or Updates. ☐ Discharge/Transfer Summaries
☐ School Records ☐ Other: ____

This authorization shall expire on ______________________________. I understand that if I do not specify an expiration date, this authorization will expire 1 year from the date on which it was signed. I acknowledge that I have read both pages 1 and 2 of this form.

____ ____________________
Patient or Guardian Signature Date

____ ____________________
Witness Date

Important Information about Authorization

Your health information is protected by the Health Insurance Portability and Accountability Act (HIPAA). HIPAA provides you or your child as a patient with important privacy rights and protections in respect to your health information, including important controls over how this health information is used and disclosed by health care providers. We take your privacy and protected health information very seriously. In some circumstances, it may be beneficial to collaborate with other professionals, entities, or other parties to coordinate or enhance treatment. You may also request that other parties or professionals be involved in your or your child's treatment. This authorization is voluntary. This authorization can be revoked or cancelled in writing at any time. Please note that we cannot take back any uses or disclosures already made before an authorization was cancelled. Information used or disclosed by this authorization may be re-disclosed by the recipient and will no longer be protected by our privacy policies.

Please be aware that there are few circumstances in which PHI can be released without a signed authorization by the patient or legal guardian, such as when subpoenaed by a judge or mandated by legal obligation in event of abuse, neglect, or significant safety concerns.

Please note that a special permission is required to release psychotherapy notes. This authorization does not cover or allow the release of psychotherapy notes. A subpoena signed by a judge is required to release psychotherapy notes.

You can address authorization revocations and/or privacy concerns to the practice HIPAA Privacy Officer:

Jeremiah Kraus
225-320-3223
jkraus@daybreaktherapysolutions.com