# INSIGHT PSYCHOLOGY, PLLC

## Confidential Authorization of Use and Disclosure
of Protected Health Information (PHI)

Patient's name: _____ Date of birth: ___-___-_____

Patient's address: _____ Phone: _____

Parent or guardian: _____ Relationship: _____

**Description of PHI that may be used and disclosed**

❑ Entire health record
❑ Intake and history
❑ Progress notes
❑ Discharge summary
❑ Diagnoses and findings
❑ Phone consultation
❑ Other (describe): _____

**Specific dates or date range(s):** _____

In the disclosure, **do not include** information about**:** ❑ Mental health; ❑ Substance use; ❑ HIV status; ❑ Other: _____

**Sender**

Name: _____ Phone: _____

Address: _____ Fax: _____

**Recipient(s)**

Name: _____ Phone: _____

Address: _____ Fax: _____

Name: _____ Phone: _____

Address: _____ Fax: _____

**Purpose of use or disclosure:**

Mutual exchange of information for the purposes of treatment coordination and planning

**Expiration date of this authorization** (if not specified, then this authorization expires in 90 days)**:**

It is my right to revoke this authorization in writing at any time. I understand that, unless indicated above, the disclosure may contain information about mental health, substance use, or HIV status. I understand that, if information is disclosed to anyone who is not subject to federal healthcare privacy regulations, then the information may no longer be protected by federal law. I understand that federal and state laws allow reasonable fees to be charged for the copying of records and that I will be responsible for the payment of any such fees. After signing this form, I will receive and keep a copy of it, and a copy will be placed in my record.

_____ ____-____-_____

**Signature of patient, parent, or legal guardian or representative** **Today's date**