Delphi Mental Health
1489 W. Warm Springs Rd. Suite 110
Henderson, NV 89014
(702) 670- 2725 - Office

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize the release of the following information obtained in the course of the treatment and diagnosis of ______Last, First________, born XX/XX/XXXX.

- ☐ Psychosocial Assessment
- ☐ Psychiatric Evaluation
- ☐ Progress Notes
- ☐ Last Three (3) Visits
- ☐ Other (please specify) _____
- ☐ History & Physical
- ☐ Lab Reports
- ☐ Treatment Goals/Outcomes
- ☐ School Records

This information may be exchanged:

Please list the specific Healthcare Provider(s) that Serenity Counseling and Support Services may exchange **Protected Health Information** with:

Name: _____

Address: _____

Name: _____

Address: _____

Please list the specific School that Serenity Counseling and Support Services may exchange **Protected Health Information** with:

Name: _____

Address: _____

This **Authorization to Disclose Protected Health Information** will automatically expire in one year on XX/XX/XXXX unless you choose to revoke this authorization prior to the date listed above. You may revoke this authorization at any time by signing at the bottom of this authorization form.

The information that is disclosed under this authorization may be disclosed again by the person or organization that receives this information. The privacy of this information may not be protected under the federal privacy regulations.

You have the right to and will receive a copy of this authorization.

I understand that by signing this form I am authorizing the above-named person or agency to disclose the listed records that may include information about mental health, terminal and/or chronic illness, and substance abuse treatment.

Name of Client/Legal Guardian (please print): _____

Client/Legal Guardian Signature: ____

Date: XX/XX/XXXX

Relationship of Legal Guardian to Client: _____

Please cancel the above authorization to release my Protected Health Information effective immediately.

Client/Legal Guardian Signature: ____________________________________ Date: _______

Serenity Counseling and Support Services
Staff Signature: _______________________________________ Date: _______

The Delphi Mental Health representative MUST notify all other staff members of the revocation of this release.