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Authorization to use and disclose protected health information

1. I am completing this form to allow the use and sharing of protected health information about

Printed Name _____ Date of birth _____

2. I authorize this person _____

3. To use or disclose the following information
   - _____ Outpatient treatment records
   - _____ Psychological evaluation(s), reports, assessments, testing records, checklists
   - _____ Information about how the patient's condition affects his or her ability to work, and to complete activities of daily living.
   - _____ Billing records
   - _____ Academic and educational records and all other school or special education documents
   - _____ Complete copy of the assessment/treatment record

3b. Dates of care included: From _____ to _____
and from _____ to _____
and from _____ to _____

4. To this person or organization _____

5. The information will be used/disclosed for the following purposes:
_____
_____

6. I understand that this authorization will be valid and in effect until _____. I understand that after that date or event, no more of this information can be used or released to the person or organization unless I sign a new authorization like this one.

7. I understand that I can revoke or cancel this authorization at any time by sending a letter to the Privacy Officer of the organization listed above. If I do this, it will prevent any releases after the date it is received but can not change the fact that some information may have been sent or shared before that date.

8. I understand that I do not have to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment from the professional or facility listed above.

9. I understand that I may inspect and have a copy of the health information described in this authorization.

10. I understand that if a person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and is no longer protected by those regulations.

11. I understand that this professional or facility may receive a small fee for the copying and use of my health information. The arrangement has been explained to me and I understand and accept it.

_____ Does not apply

12. I affirm that everything in this form that was not clear to me has been explained and I believe I now understand all of it.

_____ _____

13. Signature of client or his/her personal representative Date

_____

14. Printed name of client or personal representative Relationship to the client

15. I, a mental health professional, have discussed the issues above with the client and/or his personal representative. My observations of his or her behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____

Signature of professional Printed name of professional Date