Authorization
for
Disclosure of Protected Health Information

_____

TYPE OF INFORMATION TO BE DISCLOSED:

I hereby authorize _____ to disclose and/or receive the following protected health information:

- ❒ General Assessment Information
- ❒ General Assessment Information Specific to _____
- ❒ Other _____

PURPOSE OF DISCLOSURE / EXCHANGE OF INFORMATION:

- ❒ At client's request
- ❒ Coordinate treatment
- ❒ Other _____

RECIPIENT OF PROTECTED HEALTH INFORMATION:

_____

Addressee(s) *Institutional Class, Group, or Other Affiliation*

_____

Business Phone *Address* *City* *State / Zip*

RELEASE REQUIRING SPECIFIC CONSENT:

I am aware that my records may contain healthcare information relating to testing, diagnosis or treatment for HIV/AIDS, for any other STD, for chemical dependency, and/or for mental health. I specifically authorize _____ to disclose any and all such information, if not **excluded by initialing below:**

I intend to <u>exclude</u> from this Authorization healthcare information relating to testing, diagnosis or treatment for the following: _____ Chemical Dependency; _____ Mental Health; _____ HIV / AIDS; _____Sexually Transmitted Diseases.

CONVEYANCE OF INFORMATION: ❒ Telephone ❒ Fax/ Electronic Data Transfer ❒ Mail

REVOCATION / RE-DISCLOSURE:

I understand that I may revoke this authorization at any time by giving my health care clinician a written and signed statement of revocation, and that such revocation will not be effective to the extent that substantial action may have already been taken in reliance on the authorization, including provision of health care services requiring subsequent disclosure to effect payment. I also understand that unauthorized re-disclosure of my health information by the recipient is a potential risk. If re-disclosed, privacy laws may no longer protect the information.

DURATION:

If not previously revoked, this authorization will expire *(must specify a date, event or condition)*: _____

_____.

CONDITIONS:

I understand that I have the right to refuse to sign this authorization; however, I also understand that refusing to do so <u>may</u> condition treatment by _____.

(name of clinician)

SIGNATURE:

This authorization covers protected healthcare information pertaining to _____

(name of client)

and is effective from the date of signature below.

_____

Signature (patient, parent, guardian, or other legal representative for healthcare decisions) *Date*