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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 or organization_____

3a. To use or disclose the following information:

- Inpatient or outpatient treatment records for physical and/or psychological, psychiatric, or emotional illness.
- Admission and discharge summaries
- Psychological or psychiatric evaluation(s), reports, assessments, treatment notes, summaries, or other documents with diagnoses, prognoses, recommendations, or testing records, and behavioral observations or checklists completed by any staff member or the patient, or similar documents.
- Treatment, recovery, rehabilitation, aftercare plans and other similar plans.
- Social, family, educational, and vocational histories.
- Social work assessments, occupational therapy and vocational reports, and evaluations
- Progress, Nursing, Case or similar notes.
- Evaluations and reports of consultants.
- Information about how the patient's condition(s) affects or has affected his or her ability to work, and to complete tasks or activities of daily living.
- Billing records.
- Academic and educational records, including achievement and other test results, reports of teachers' observations, and all other school or special education documents.
- HIV-related information and drug and alcohol information contained in these records will be released under this authorization unless indicated here –
  - do not release these.
  - Other information: _____

_____

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

4. To this person or organization_____

_____

5. The information will be used/disclosed for the following purposes: [next page}

_____

_____

6. I understand and agree 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 and which is to supply this information. If I do this, it will prevent any disclosures after the date it is received but cannot 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 at number 2 above.

9. I understand that I may inspect and have a copy of the health information described in this authorization. There may be a cost for this copy or other services.

10. I understand that if the 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 disclosed and no longer protected by those regulations.

11. I understand that the professional or facility listed in number 2, above, may receive compensation for the use or disclosure of my health information. If that is the case, I understand and accept it.

12. I affirm that anything in this form that was not clear to me has been explained adequately for my understanding. I have also received a copy of this completed form

_____ _____

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

_____ _____

Printed name of person in item 13 Relationship to person in item 13

_____

Description of personal representative's authority

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

_____ _____ _____

Signature of professional receiving authorization Printed name Date