Sample Authorization for Use of Protected Health Information:

Authorization for Use of Protected Health Information

Patient Name: ____
Date of Birth: _________________________ Record #: ____________________________

I authorize [Practice name] to disclose my mental health information specific to the following date or time period: ____

Individual or entity authorized to receive my mental health information:
____

Purpose for which disclosure is to be made: _____________________________________
____

Information to be disclosed:

- ❒ Discharge Summary
- ❒ Psychological Report
- ❒ Social History
- ❒ Psychological Test Data
- ❒ Progress Notes
- ❒ Consultation
- ❒ Treatment Plan
- ❒ Other ____

I understand that this will include mental health information relating to (check of applicable):

- ❒ HIV(human Immunodeficiency Virus) infection
- ❒ Mental Heath
- ❒ Treatment for alcohol and/or drug abuse
- ❒ Psychological Testing

1 understand that if the person(s) or entity(ies) that receives the information is not a mental 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. Therefore I release [Practice name], its employees, and my therapists from all liability arising from this disclosure of my mental health information.

1 understand that I may inspect or request copies of any information disclosed by this authorization. It is my understanding that this authorization will expire; in 90 days from the date signed below. I understand that I may revoke this authorization by notifying, in writing, the

[Practice name], knowing that previously disclosed information would not be subject to my revoke request.

1 understand that l may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment or my eligibility for benefits.

________________________________ ______ ___________________ _______
Signature; Patient or Legal Representative Date Signature of Witness Date