Health Annex
Holistic Health Co-op

Authorization for Use or Disclosure of Protected Health Information

Client Information

Client Last Name_____ First Name _____DOB:___/___/____
Client Address

_____

Client Home Phone: _____ Cell/Work Phone:_____
Client Email Address: _____

Recipient Information

I, _____, do hereby authorize _____ to release a copy of my mental health information to the person or facility below.
Name of person/facility to receive medical information:

_____

Phone: _____
Address: _____
Date of Authorization: ___/___/_____
Authorization to expire on ___/___/_____ or upon the happening of the following event: _____

_____

Information to be Released (*Note: Requests for release of psychotherapy notes cannot be combined with any other type of request.*)
☐ My entire mental health record
☐ Only those portions pertaining to: _____
(Specific provider name and/or dates of treatment)
☐ Authorization for Psychotherapy Notes ONLY (Important: If this authorization is for Psychotherapy Notes, you must not use it as an authorization for any other type of protected health information.)
☐ Other: _____

Purpose of Information Release:
☐ Further mental health care ☐ Payment of insurance claim ☐ Legal investigation
☐ Applying for insurance ☐ Vocational rehab, evaluation ☐ Disability determination
☐ At the request of the individual ☐ Other (specify): _____

Authorization and Signature

I authorize the release of my confidential protected health information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient unless the recipient is
covered by state laws that limit the use and/or disclosure of my confidential protected health information.

_____ _____

Signature Date

If signed by a personal representative:

(a) Print your name: _____

(b) Indicate your relationship to the client and/or reason and legal authority for signing:

Patient is: ☐ minor ☐ incompetent ☐ disabled ☐ deceased

Legal authority: ☐ parent ☐ legal guardian ☐ representative of deceased