

**AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION**

Client Name: \_\_\_\_\_

DOB: \_\_\_\_\_

I authorize my psychologist \_\_\_\_\_  
to: (initial all that apply)

- Receive a copy of my specific health information from the person(s) named below  
 Send a copy of my specific health information to the person(s) named below

To/From: \_\_\_\_\_  
\_\_\_\_\_

(Name, address and phone number of person who will send or receive information)

I authorize this information to be used for: (initial all that apply)

- |  |   |
|--|---|
| <input type="checkbox"/> Continuation of mental health care  | <input type="checkbox"/> Coordination with education services |
| <input type="checkbox"/> Coordination with medical providers | <input type="checkbox"/> Completion of evaluation             |
| <input type="checkbox"/> Legal issues (specify) _____        | <input type="checkbox"/> Other (specify) _____                |

I authorize the exchange of the following information: (initial all that apply)

- |  |  |
|--|--|
| <input type="checkbox"/> Mental health session notes           | <input type="checkbox"/> Billing records       |
| <input type="checkbox"/> Mental health treatment summary       | <input type="checkbox"/> School records        |
| <input type="checkbox"/> Psychological evaluation reports      | <input type="checkbox"/> Other (specify) _____ |
| <input type="checkbox"/> Other medical records (specify) _____ |  |

I understand that any information that is exchanged with another person will be protected if that person is required to comply with the Federal Privacy rule. If privacy laws do not apply, the information may not be protected and could be re-disclosed without authorization.

I understand that I may refuse to sign this authorization. My refusal to sign will not prevent me from receiving mental health services or reimbursement for services. The only exception is if the services are solely for the purpose of providing information to someone else and this authorization is necessary to make that disclosure.

I understand that I may revoke this authorization at any time. If I revoke this authorization, it is no longer valid. The only exception is when the authorization was obtained as a condition of obtaining insurance coverage. However, any information exchanged before I revoke this authorization cannot be retrieved. To revoke this authorization, please send a written statement revoking the authorization to:

\_\_\_\_\_

Unless revoked, this authorization will expire in: (initial one)

- one year  on termination of mental health treatment  
 other (indicate expiration date or event): \_\_\_\_\_

I have read this authorization and I understand it. This completed authorization must be signed by the client or a person authorized by law to represent the client. A copy of this authorization is as valid as the original.

\_\_\_\_\_  
Signature of Client or Client's Representative

\_\_\_\_\_  
Date

Description of representative's authority: \_\_\_\_\_