# Authorization to Use and Disclose Protected Health Information (PHI)

Client name: _____ Previous name: _____ Date of Birth: _____

Address: _____

Phone number: _____ Email: _____

I, _____, _____ _____ hereby authorize the release of _____health care information
(Name of client or representative) (Relationship to client) (Client/Child's/Other)

**TO / FROM (circle one or both):**

Name and Organization: _____

Address: _____

City, State: _____Zip Code: _____Phone: _____

**TO / FROM (circle one or both):**

Name and Organization: _____

Address: _____

City, State: _____Zip Code: _____Phone: _____

**By signing this Authorization, I authorize the use and disclosure of all health information, including the following:**

☐ All Health Care Information about client, including clinical records. This information may include, if applicable:

| Yes | No | |
|---|---|---|
| ☐ | ☐ | Information about mental health diagnosis or treatment. |
| ☐ | ☐ | Information about diagnosis or treatment for alcohol or drug use, abuse, or dependence. |
| ☐ | ☐ | Information about HIV/AIDS Testing or Treatment (including the fact that an HIV test was ordered, performed or reported, regardless of whether the results of such tests were positive or negative). |
| ☐ | ☐ | Information about diagnosis or treatment of Sexually Transmitted Disease(s) or Infections. |

☐ Specific Health Information *including only*: _____

**For the Purpose(s) of:** ☐ Continuity of care ☐ Client request ☐ Disclosure for legal purposes_____
_____ ☐ Legal procedure ☐ Other _____

**This authorization ends: (check one box)** ☐ in one (1) year ☐ 90 days (if no other event)
☐ when the following occurs: _____

**I UNDERSTAND AND ACKNOWLEDLGE THAT:** My records may contain information related to my mental health; my written consent is required to release any health care information related to testing, diagnosis, and/ or treatment for HIV (AIDS virus), psychiatric disorders/mental health, and or drug and/or alcohol use unless otherwise allowed or required by law; this authorization prohibits further use of disclosure of the information being released beyond the specific limits of this consent; I may refuse to sign this authorization or revoke authorization in writing at any time, except to the extent that the action has already been taken in reliance of it; information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of my information and no longer protected by this provider, office, or HIPAA regulation; and commencement, continuation, or quality of treatment will not be conditioned on whether I sign this document except insofar as PHI is necessary to assessment, report, or treatment contemplated by this authorization. However, failure to sign here may result in a denial of insurance benefits by your insurer. PHI may be conveyed in writing, fax, or verbal/telephone communication. Photocopy of this release has the same force and effect as the original. **I have received a copy of my signed authorization.** I hereby release the provider of my PHI from any and all legal liability that may arise from the use and disclosure of information as set forth in this Authorization.

_____ _____
Signature of client or legally authorized representative Date Time

_____
Relationship if signed on behalf of the client by parent, legal guardian, personal representative, etc.