



Transformative Vision

Authorization for Use or Disclosure of Protected Health Information

Client Information

Client Last Name _____ First Name _____ MI ____ 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